CHERBOURG PSYCHOLOGY AND COUNSELLING SERVICE
REFERRAL FORM

**Please note if crisis assistance is required, please contact Emergency Services on 000 or your local Mental Health Service Acute Care Team.*

Referral Date:		**Client or Parent/Guardian/Carer consent for this referral** *(if aged 12-18):* • Yes • No

REFERRER DETAILS

Name of referrer:		**Organisation:**	
Referrer position/ profession:		**Provider number:** *(if applicable)*	
Phone:		**Email:**	
Address:			• Experiencing homelessness

CLIENT DETAILS:

Name:		**Preferred Name**	
D.O.B.		**Gender:**	
• Aboriginal • Torres Strait Islander • Both • Neither			**• Culturally & Linguistically Diverse Background**
Address:			
Phone numbers:			
Email:			
Parent/Carer/ Guardian Name: *(if aged 12-18)*		**Relationship to youth:**	
Contact details:			

ADDITIONAL INFORMATION:

Reason for Referral:			
Client goals and hopes:			
Key Issues identified by client and worker:	• Psychological support • Physical health • Housing/Accommodation • Substance use • Financial • Employment	• Relationships • Domestic & Family Violence • Social • Education • Isolation	• Other:
Mental Health Diagnosis:			

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(if applicable)	
Mental Health Care Plan completed:	• Yes (please attach) • No
Medication details: *(if applicable)*	
Outcomes/scores of any relevant psychosocial assessments: (*e.g. K5, K10, SDQ*)	
Risk of harm to self:	Is the person currently self-harming • Yes • No Is the person at increased risk of suicide • Yes • No **If assessed at high risk of suicide please contact Emergency Services on 000 or Mental Health Service Acute Care Team*
Are there any risk factors we should be aware of?	• No • Yes (please specify below or attach existing risk assessment)
Other services client is accessing:	
Other relevant information:	

CLIENT PREFERENCES

Preferred Gender of Worker:	• Female • Male
Preferred contact method:	• Mobile • Home phone *Ok to leave voicemail/send SMS: • Yes • No • Email • via Referrer • Home visit
Other preferences:	

This form can be delivered to Wakai Waian Healing by:

Fax: 07) 4829 4011, **Email:** referralscq@wakai-waian.com.au

Further Information:
Freecall: 1800 732 850 or Email: enquiries@wakai-waian.com.au

OFFICE USE ONLY	Date	Initials	Notes
Confirmation sent to Referrer			
Entered on RefeRHEALTH			
Referrer notified of referral outcome			