**REFERRAL FORM *- (Please ensure one form per individual)***

**Chart No: TGA WHK TOK WAI**

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| ***Name of Referrer/Service:***  ***Address:*** | | | | |
| ***Date of Referral:*** | | | ***Appt for: Medical Counselling*** | |
| **Name of Client:** | | | | |
| **DOB:** | **Age:** | | | **NHI (if known):** |
| **Gender:** | **Ethnicity:** | | |  |
| **Client Address:** | |  | | |
| **Home phone number:** | | | **Mobile number:** | |
| **Email:** | | | | |
| **Preferred method to contact: Phone € Txt € Voicemail € Email €** | | | | |
| **If Under 16yrs, - primary caregiver name and contact:**  **Primary caregiver consent Yes € No € Not aware €**  (*If you want the appointment details to be given to someone else please indicate here)***:** | | | | |
| **Appointment details to go to:**  (*If you want the appointment details to be given to someone else please indicate here)***:** | | | | |
| **OT contact *(name, phone number, email address):*** | | | | |
| **Police contact *(name and contact details):*** | | | | |
| **GP name and address:** | | | | |
| **Person accompanying child to appointment:** | | | | |
| **Safety Risk assessment: Low € Moderate € High €**  **Safety Plan: No € Yes € (Please attach copy)** | | | | |
| **Nature of concern: *Please include as much information as possible; timeframes, nature of offences, current mood, any previous medical appts, safe contacts, any physical symptoms or worries client may have – any special needs – cultural, spiritual or disabilities*** | | | | |
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