**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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