FREMANTLE WOMEN'S HEALTH CENTRE

COUNSELLING SERVICE REFERRAL FORM

CLIENT DETAILS

Client Name: _____ Date of Referral: _____
Address: _____
DOB: ___/___/___ Email Address: _____
Phone Numbers: Mobile: _____Home: _____Work: _____
Country of Birth: _____ Aboriginal ☐ Non Aboriginal ☐
Preferred Language: _____ Interpreter Required? ☐ Yes ☐ No
Relevant Family Information: Current Partner? Yes ☐ No ☐ Name: _____
Children:
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____
Name: _____ DOB: ___/___/_____
Other significant family/supports: _____

REASON FOR REFERRAL

Presenting Issue/ Reason for Referral: _____

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Has this Client accessed counselling/ therapy previously? Yes ☐ No ☐
If yes, how long since last counselling? _____

Physical & Emotional Health

Pregnant: Yes ☐ No ☐ Due Date: _____ Injuries:_____
Disability: _____ Illness: _____
Drug/ Alcohol Issues:_____ Current Risk Factors: _____
Current Prescription Medications: _____

_____

Client's Current GP: Name: _____ Frequency of contact: _____
Address: _____
Phone Number: _____ Email Address: _____
Other Significant Health Practitioner: _____

Please turn over

REFERRAL CONTACTS

Referring Agency/Practitioner / Contact Name: _____

Name: _____ Position: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Ongoing contact with client? Yes ☐ No ☐

Please indicate how long you have known/ treated this client: _____

Other referrals in place? Yes ☐ No ☐ If yes please outline: _____

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Other Comments: _____

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Thank You for your referral and information. We will report back to you with the outcome as soon as possible.

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