

Fremantle Women's Health Centre Service Referral Form

Please sign and submit this form to FWHC either by e-mail enquiries@fwhc.org.au or by Fax 9430-7862

Referral Date:
Is this a referral for (please tick all that apply)

<input type="checkbox"/> Individual counselling	<input type="checkbox"/> Group work:
<input type="checkbox"/> Specialist women's health nurse/ doctor	<input type="checkbox"/> Both Individual counselling and Group work:

Client Details

First Name:	Last Name:	Preferred Name/ Alias:
DOB:	Interpreter Required? Yes No	Interpreter Language:
Home Phone:	OK to phone? Yes No	OK to leave Message? Yes No
Mobile:	OK to phone? Yes No	OK to leave Message? Yes No
E-mail address:	OK to send Message? Yes No	
Preferred method of contact:	e-mail text Mobile	Home Phone
Does the client have a disability Yes No	If yes, Please describe along with assistance required if any	
Is the client pregnant? Yes No	Unknown	If yes, Due Date
If referring to Specialist Nurse/ Doctor, please describe physical health issues and reason for referral:		
Presenting Issues/ Reason for Referral for Counselling including recent stressors, current domestic and social circumstances		
Mental Health History if relevant (Relevant biological, psychological, alcohol and other drug use, social, medical and family history information including suicidal behaviour:		
Any outcome tools you have used –include date of assessment and results. E.g. EPDS, Details:		

Risk Assessment (please tick all that are relevant)

Family and Domestic Violence	No History	Past	At high risk of serious harm	At risk of harm	Suspected	Unknown
Further details						

If you have filled in a WA Family and Domestic Violence Common Risk Assessment Tool, please attach it with your referral.

	Unknown	None	Ideation/thoughts	Intent	Plan
Suicide					
Self-Harm					
Harm to others including children in client's care					
Further details on identified risks					

Referring Agency/ Service Provider details	Role :
Your Name:	Organisation:
Work Phone:	Mobile:
Fax:	e-mail:

I, _____, (Service Provider's name) have discussed this referral with my client and my client has given verbal consent to be referred to FWHC. Signature _____ Date _____

Thank you for your referral. We may need to contact you to gain additional information, especially around risk.