

 **REFERRAL FORM PRIVATE AND CONFIDENTIAL**

**Date of contact:**



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| **CLIENT DETAILS** |
| Full Name: Date of Birth: |
| Gender: Male Female Self-described Preferred Pronouns:  |
| Address: Post code: |
| Phone: Email Address: |
| Preferred contact method: Phone email Is it safe to leave a message : Yes NoAlternate contact method: Preferred time to call:   |
| ATSI: Aboriginal Torres Strait Islander Both Neither |
| CALD: Country of Birth: Preferred Language: |
| Literacy competency: Yes No, please specify:  |
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| **SERVICE CRITERIA** |
| Has the client given consent for GdA to contact them: Yes No  |
| Are they A returning client: Yes No How did they hear about GdA:  |
| Self-Described disability: Primary, Secondary: |
| Legal representative/orders: P.O.A State Trustees Plan Nominee Guardian Other, please specify: |
| Do they receive Government payment: please specify, NDIS participant. |
| **ADVOCACY/APPEALS ISSUE** |
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| **Are there any important dates related to this issue: No Yes please specify;** **Appeals : DSP review: Court dates:****Other, please specify:** |
| **INFORMAL SUPPORTS** |
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| **FORMAL SUPPORTS**  |
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| **RISK ASSESSMENT** |
| Are there any safety concerns for you or someone in your family: No Yes please specify: Homelessness Family Violence AOD suicide Justice system Access to healthcare  Other, please specify:  |
| Do you have a safety plan: No Yes Please specify : |
| **REFERRER DETAILS** |
| Name: Program: |
| Organisation: |
| Email: Phone: |
| Address: Postcode: |
| Preferred method of contact: Phone Email |
| Will you continue to support client after this referral: Yes No |