|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Email Completed form to** [**Intake@gallangplace.org.au**](mailto:Intake@gallangplace.org.au)  *ALL information on this form is treated as confidential as per Gallang Place’s Policies and Procedures* | | | | | | |
|  |
| ***OFFICE USE ONLY:*** | | | | | | |
| Intake Officer |  | | | DATE RECEIVED | |  |
| ProGRAM | Fee For Service  EAP  ADult  Youth  Other | | | | | |
|  | | | | | | |
| ***Client Details*** | | | | REFERRAL DATE | |  |
| Name |  | | | DATE OF BIRTH | |  |
| Home Address |  | | | Client Email | |  |
| PHONE |  | | | used gallang services before? | | Y N |
| GENDER | MALE FEMALE OTHER | | | | | |
| I Identify as: | | ABORIGINAL | TORRES STRAIT  ISLANDER | | BOTH | |
| next of kin | |  | Emergency Contact | |  | |
| **If the client is under the age of 18 years of age the Parent/Guardian must complete the following:**  I consent to my child being seen by a Counsellor.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name** **of Parent/Guardian**     **Signature** of Parent/Guardian  **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PLEASE NOTE:  This referral cannot be actioned without the signature of the Parent/Guardian** | | | | | | |
| **Type of Support:** | | | | | | |
| Anger Management  Behavioural  Domestic Violence | | Drug / Alcohol  Grief and Loss  Relationship | Suicide / Self Harm  Self-esteem  Trauma | | Anxiety  Depression  Workplace issues  Other, *please specify in*  *notes section* | |
| ***Notes***  *I have attached additional information* | | | | | | |
|  | | | | | | |
|  | | | | | | |
| ***Referrer Details IF self Referral –*** *please identify other service providers* | | | | | | |
| REFERRER Name | |  | Relationship | |  | |
| REFERRER email | |  | | | | |
| REFERRER Contact No. | |  | AGENCY [IF APPLICABLE] | |  | |