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| --- |
| **Email Completed form to** **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] |  |