GALLANG PLACE
Aboriginal and Torres Strait Islander Corporation

INTAKE FORM

V5 03/10/2024

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]	