

**PHOENIX SUPPORT & ADVOCACY SERVICE Inc.**

**Formerly ISA - Incest Survivors Association (Inc.)**

**CLIENT REFERRAL FORM**

*Phoenix Support & Advocacy Service works therapeutically with adults, young people and children (aged from 5 years onwards) and their families, to reduce the impact of childhood sexual abuse, to reduce the likelihood of children and young people engaging in concerning or sexually inappropriate behaviours and to reduce the likelihood of future sexual abuse occurring.*

**\*This form needs to be completed for the referral to Phoenix to be accepted\***

**REFERRING AGENCY INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** | | | | **Referrer’s Name:** | | | |
| **Agency:** | | | | **Phone Number:** | | | |
| **Address:** | | | | | | | |
| **Email:** | | | | | | | |
| **Reason for Referral**  Tick the box for the main reason the individual / family is being referred | Young person or Child/ren who has/have experienced sexual abuse |  | Child/ren who is/are engaging in problematic sexual behaviour | |  | Adult / Family member affected by childhood sexual abuse |  |

**CLIENT INFORMATION**

|  |  |
| --- | --- |
| **Client Name:** | |
| **DOB:** | **Gender:** |
| **Address:**  **Postcode:** | |
| **Telephone:** | **Mobile:** |
| **Best times to call: Can we leave a message: YES No** | |
| **Email Address:** | |

Please complete table below and **include all people living with the referred individual**. Please identify the primary person(s) who is/are being referred for counselling services, by marking an **X** in the “referred for counselling” shaded column.

*Please note that when children are referred there is an expectation that the parents/carers will engage with the service and be involved in the counselling process*.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Surname** | **First Name** | **Date of**  **Birth** | **Gender** | **Ethnicity** | **Relationship to Referred** | **Referred for Counselling** |
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Other agencies involved with the individual / family

(Please provide agency name and contact details):

**REFERRAL INFORMATION**

**Reason for referral**

**Purpose of the Referral**

What are the referring agency’s goals for this individual / family, in relation to this referral to Phoenix?

**Other Issues**

Discuss family relationships, including any incidences of domestic and family violence and nature of bonding and attachment if the referred individual is a child or young person. Drug and alcohol use, known risks (e.g. suicidal ideation, self-harm, harm to others) or mental health issues etc.

*Please also note any challenges or specific needs related to language, literacy and/or disability*

**Preferred support required**

|  |  |  |  |
| --- | --- | --- | --- |
| Individual Counselling |  | Family Counselling |  |
| Couple Counselling |  | Group Counselling |  |
| Phoenix recommendation requested | | |  |

**Urgency**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Within one week |  | Within one month |  | When available |  |

**Client Consent for Referral**

(Please Note: Phoenix will not accept referrals without client consent)

|  |  |
| --- | --- |
| Has client (adult) consented to the referral? | YES / NO |
| Does the child (ren) / young person agree with the referral to counselling? | YES / NO |
| Does the parent/s agree with the referral(s) for counselling? | YES / NO |
| Are the parent’s willing to participate in the program? | YES / NO |

Will you have ongoing contact with client? YES / NO

Details:

Does your agency require feedback? YES / NO

What kind and in what form?

**Please complete and return Referral Form to Phoenix Support & Advocacy Service Allocations Officer along with a signed consent to share information form (attached) to:**

**Email:** [**counsellor@phoenix.asn.au**](mailto:counsellor@phoenix.asn.au)

**Fax: (08) 9227 1510**

**Post:** 404 Walcott Street, Coolbinia WA 6050