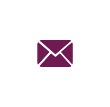
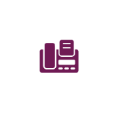


61 8 9443 1910

61 8 9227 1510

info@phoenix.asn.au

404 Walcott Street, Coolbinia WA 6050



**CLIENT REFERRAL FORM**

*Phoenix Support & Advocacy Service Inc. currently works therapeutically with adult survivors of child sexual abuse. Phoenix also works with those impacted by a disclosure of child sexual abuse such as family members, friends or significant others.*

**\*This form needs to be completed, along with a signed consent to share information form, 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 | Adult who has experienced sexual abuse as a child |  | | Adult family member or significant other impacted by a disclosure of 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** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

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, drug and/or alcohol use, known risks (e.g. suicidal ideation, self-harm, harm to others) or mental health issues etc. Please include any information related to any formal mental health diagnosis and any medication prescribed.

*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 |
| If yes, has a copy of the signed consent form been attached? | YES / NO |
| Has the client also consented to information being shared? | YES / NO |
| Has the client consented to family members or significant others also accessing the service? | 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 the Referral Form and a signed Consent To Share Information Form, to Phoenix Support & Advocacy Service Allocations Officer to:**

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

**Fax: (08) 9227 1510**

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