**CLIENT REFERRAL FORM**

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| 1. **REFERRAL CRITERIA Please note the following criteria before proceeding with a referral** |

* Adult aged **18+** who is a survivor of childhood sexual abuse **OR**
* Adult impacted by a disclosure of child sexual abuse such as a family member, friend, or significant other
* The person/s being referred reside within the Perth metropolitan area
* Signed consent from the person/s being referred is required to proceed
* This consent includes agreement for information sharing
* Any ongoing court matters must be disclosed
* Phoenix is not funded to provide crisis services, however, see website for crisis information
* Phoenix does not provide services for perpetrators or convicted offenders of child sexual abuse

**PLEASE NOTE:** The information sought in the referral form assists Phoenix to determine if the service is suitable and/or appropriate, and aims to minimise the referred person/s having to repeat information they have already disclosed where it is not necessary to do so.

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| 1. **REFERRING AGENCY INFORMATION** | | | | |
| **Date of Referral:** | | | **Referrer’s Name:** | |
| **Agency:** | | | **Phone Number:** | |
| **Address:** | | | | |
| **Referrer’s Email:** | | | | |
| **Reason for Referral**  Please tick the box with the main reason the individual / family is being referred | Adult who has experienced sexual abuse as a child. | | | Adult family member, partner or significant other, impacted by a disclosure of childhood sexual abuse. |
| 1. **CLIENT INFORMATION** | | | | |
| **Client Name:** | | | | |
| **DOB:** | | **Gender:**  F  M  Diverse gender identity  Gender unknown  **Preferred Pronoun:** | | |
| **Address:**  **Postcode:** | | | | |
| **Telephone:** | | **Mobile:** | | |
| **Preferred Methods of Contact: Can we leave a message: YES NO** | | | | |
| **Ethnicity: ATSI  / CaLD  / Other** (Ethnicity which is not ATSI or CaLD) **/ Ethnicity unknown** | | | | |
| **Household / Family Structure:** Single  / Couple  / With Children  / Without Children  /  With non-child dependants  / Extended family  / Kinship group | | | | |
| **Email Address:** | | | | |

If referring individuals that have been impacted by a disclosure of child sexual abuse, then please complete the 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.

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| **Surname** | **First Name** | **Date of**  **Birth** | **Gender** | **Ethnicity** | **Relationship to Referred** | **Referred for Counselling** |
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| 1. **OTHER AGENCIES INVOLVED** |

Please provide agency name and contact details of any other agencies involved with the individual/family:

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| 1. **REFRERAL INFORMATION** |

**Reason for referral:**

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| 1. **OTHER ISSUES – RISKS, BARRIERS, and OTHER FACTORS** |

Please tick below the information that is relevant to the person/s you are referring. Please disclose family relationships, including any incidences of domestic and family violence, drug and/or alcohol use, known risks (e.g., suicidal ideation, self-harm, medication prescribed).

**RECENT LOSSES / CHANGE / KEY EVENTS** Please specify any changes in previous 12 months

Physical Illness self / significant other

Loss of home / employment

Mental Health Issues self / significant other

Commenced new job

Taken on a carer role for significant other

Workplace concerns e.g., bullying

Self-harm self / significant other

Moved house / location / employment

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Bereavement Death of grandmother/Mother/Father

Divorce /separation / relationship conflict or breakup

New relationship / engagement / marriage / planned wedding

Pregnancy / birth of child

Accidents self /significant other

Miscarriage / abortion / still birth

**IDENTIFIED CONCERNS**

Self Esteem

STIs

Trauma / Abuse

Bereavement / Loss

Interpersonal relationship issues

Addictions

PTSD

Physical Problems

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression

Anxiety / Stress

Anger management

Self-Harm

Eating Disorder

Domestic Violence

Sexual Violence

Living / Welfare

Work / Academic

Pornography compulsions

Sexual acting out of abuse / sex work

**LIFESTYLE**

Full time carer

Living in shared accommodation

Living in temporary accommodation

Living in institution / hospital

Other

Living alone

Living with partner

Caring for children under 5

Caring for children over 5

Living with parents / guardian

Living with other relatives / friends

**MENTAL HEALTH**

**Any Mental Health Diagnosis:**

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**Current or previous use of services for challenges** or symptoms as an impact of trauma?

GP  Outpatient treatment

Counsellor, mental health nurse  Inpatient treatment

Psychotherapy, psychological services  Psychiatrist

**Is the client currently prescribed medication to help with the impact of trauma?** YES NO

If yes, please indicate type of medication:

Anti-psychotics Anti-depressants Anxiolytics/Hypnotics Other

Name of medication/s (if known):

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**Any further information:**

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| 1. **COPING / RESOURCES / PROTECTIVE FACTORS / STRENGTHS** |

What is your understanding of how the client has coped with / or avoided dealing with their trauma? Please include information about their current self-regulation and self-care strategies. Please include below any further information related to the issues identified in the check boxes and/or any information related to a formal mental health diagnosis including any medication prescribed.

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**SPECIFIC NEEDS – LANGUAGE, LITERACY CHALLENGES AND/OR DISABILITY**

interpreter required  wheelchair access

support person attending  therapy support animal attending

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you referred the client for any other support Yes No

If **YES**, please provide further details below:

* *Please be aware that there may be a waitlist.*
* *If this is the case, we will assess the person/s at the earliest opportunity to review suitability for the service prior to their placement on the waitlist. This also allows the person/s to assess if Phoenix is a ‘right fit’ for them.*
* *To reduce client expenses and travel time, Phoenix -provides appointments online via the internet. Online counselling from the client’s home can reduce anxiety and enhance a sense of safety. If in-person counselling is preferred, then this can be provided on request.*
* *For a list of telephone crisis, counselling and support services please go to* [*www.phoenix.asn.au*](http://www.phoenix.asn.au)

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| 1. **CLIENT CONSENT FOR REFERRAL CHECKLIST** |

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| Has the adult person/s referred 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 |

**PLEASE NOTE: Phoenix will require a copy of a signed consent form to be able to share information and /or discuss the referral with you.**

Will you have ongoing contact with the person/s referred? YES / NO

Details:

Do you and/or your agency require feedback? YES  / NO

If so, what kind and in what form?

**Thank you for providing comprehensive information in this referral.**

* This helps minimise the person/s referred being negatively impacted by repeating information and/or revisiting details unnecessarily.
* Please be aware Phoenix staff may contact you for further information.

**Please complete and return this Referral Form to Phoenix Support & Advocacy Service:**

**Email:** [**counsellor@phoenix.asn.au**](mailto:counsellor@phoenix.asn.au) **Post:** 404 Walcott Street, Coolbinia WA 6050

If you require further information or have any questions, please phone (08) 9443 1910 during business hours as shown on the Phoenix website [www.phoenix.asn.au](http://www.phoenix.asn.au)