**CLIENT REFERRAL FORM**

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| 1. **REFERRAL CRITERIA Please note the following criteria before proceeding with a referral**
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* 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 at the time of referral
* Phoenix does not provide services for perpetrators or convicted offenders of child sexual abuse
* Phoenix is not funded to provide crisis services, however, see the Phoenix website for crisis information [www.phoenix.asn.au](http://www.phoenix.asn.au)

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

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| 1. **REFERRING AGENCY INFORMATION**
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| **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**
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| **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 [ ]  |
| **Client 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**
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Please provide agency name and contact details of any other agencies involved with the individual/family:

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| 1. **REFERRAL INFORMATION**
 |

**Reason for referral:**

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

[ ]  Substance use

[ ]  PTSD

[ ]  Physical issues

[ ]  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:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

[ ]  GP [ ]  Outpatient treatment

[ ]  Counsellor [ ]  Inpatient treatment

[ ]  Psychotherapy, psychological services [ ]  Psychiatrist

[ ]  Mental Health Nurse [ ]  Unknown

**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 other health information of relevance including how the condition is being managed:**

(e.g., ADHD; epilepsy; diabetes)

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

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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:

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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?

* *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)

**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** **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)