# GLADSTONE WOMEN'S HEALTH CENTRE REFERRAL FORM

Please email this form to: **intakes@gladstonewomenshealth.org.au**

| **PERSON MAKING REFERRAL:** | |
|---|---|
| Name: | |
| Position: | |
| Organisation: | |
| Contact Number: | |
| Email Address: | |
| Preferred Method of Feedback: | ☐ Email ☐ Phone ☐ No Feedback |
| **CLIENT DETAILS:** | |
| Name: | ☐ Male ☐ Female ☐ Other |
| Date of Birth: | |
| Address: | |
| Postal Address (if different): | |
| Home Phone: | ☐ Preferred Contact |
| Mobile Phone: | ☐ Preferred Contact |
| Email Contact: | ☐ Preferred Contact |
| Is it safe to leave a message? | ☐ Voicemail ☐ SMS |
| Does the client have dependent/s?<br>If so, state age/s and gender/s: | ☐ No ☐ Yes |
| **PREVIOUS COUNSELLING DETAILS:** | |
| Has the client previously accessed services at Gladstone Women's Health?<br>If so, for which support service?<br><br>Approximately, when did this occur? | ☐ No ☐ Yes<br>☐ Sexual Assault ☐ General Women's Health<br>☐ Domestic & Family Violence |
| **DOMESTIC AND FAMILY VIOLENCE:** | |
| Is there any current or historical domestic and family violence?<br>If yes, please briefly describe:<br><br>Name of Perpetrator (if known): | ☐ No ☐ Yes |

| SAFETY/RISK ASSESSMENT: |
|---|
| Do you have any immediate concerns for the safety of your client or her children? ☐ No ☐ Yes<br>*(eg. Adult survivor of child sexual assault, child victim of child sexual assault or adult sexual assault survivor?)*<br><br>If so, please describe briefly: |
| **SELF HARM:** |
| Is there any history of self-harm? ☐ No ☐ Yes<br>*(eg. Cutting, eating disorders, intentional overdose, suicide attempts)*<br><br>If so, please describe briefly: |
| **SUBSTANCE ABUSE:** |
| Does the client have a history of any drug or alcohol abuse? ☐ No ☐ Yes<br>If so, please describe briefly: |
| **SUPPORT SERVICES:** |
| Is the client currently engaged with any other support services? ☐ No ☐ Yes<br>*(eg. UCC, Mental Health, Women's Refuge, etc)*<br><br>If so, please describe briefly: |
| **REASON FOR REFERRAL AND ANOTHER OTHER AREAS OF CONCERN:** |
| |

*Australian Privacy Principle #5: Notification of the collection of personal information.*

☐ I have notified the client regarding the nature of the information disclosed on this form and the client is fully aware of this referral.

Signature: _____ Date: _____