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| **Service Request:** Please tick which service is requested: **[ ]  Therapeutic Counselling/ Mediation [ ]  Financial Counselling [ ]  Older Person Support-Coordinator (OPSC)**  |
| **Date of Referral:** | **Consent for Referral** |
|  [ ]  Client consent obtained  |
| **Client Details**  |  |
| Family Name:  | Date of Birth:  | Marital Status: Select |
| Given Name: | Country of Birth:  |
| Address:  | Phone:  | Mobile:  |
| **Best time/day for safe contact:** | Email:  |  |
| Language:  | Interpreter required[ ] Yes [ ]  No | ***GP*** *(If known)* **Consent to contact GP** Choose an item. |
| Indigenous Status: Select | *Name:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_Address:  |
| DVA: [ ] YES [ ] NO Type:  | DVA Number: |
| Medicare Number: | Pension Type: | Pension Number  |
| Housing Type: Select  |
| Location of client: [ ] Hospital / Ward [ ]  Community (Specify):  |
| **Contact Person:**  |
| Name:  | Relationship:  |
| Address:  | Home number:  | Work number:  |
|   | Mobile number:  |  |
| **Referrer Details** |
| Name of Referrer :  | Organisation:  |
| Contact: Mobile: Work: | Email address:  |
| Alternate contact detail if unavailable: |
|  **Reason for Referral:**  |
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| **Suspected Abuse Type:**  |
|  |
| **Safety:** MARAM risk Assessment completed [ ]  Yes [ ]  No (If yes, please attach)  |
| Has a safety plan been developed for the client? [ ]  Yes (provide details) or [ ]  No [ ]  Unknown  |
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| Any known factors which may place client/ staff at risk of harm? [ ]  Yes (provide details) or [ ]  No [ ]  Unknown |
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| Any legal orders in place? [ ]  Yes [ ]  No (If yes, please attach or describe)  |
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| **Discharge Plan (hospital inpatient only), Current Community Supports, Other…** |
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| **Counsellor/ OPSC Triage (Completed by EALO)**  |
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| **Written consult advice available**  **[ ]  Yes [ ]  No**  |
| **Referral accepted [ ]  Yes [ ]  No Date Accepted:** |