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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:** | | | | | | |
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| **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:** | | | | | | |