**Illawarra Women’s Health Centre**

**Interagency Referral Form**

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| **Referrer information** | |
| Name |  |
| Agency or Organisation |  |
| Email |  |
| Telephone number |  |
| Is your client aware of long wait times for our counselling services (if relevant)? |  |
| Has your client consented to this referral? |  |
| Date |  |

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| **Client information** | |
| First Name |  |
| Last Name |  |
| Date of birth |  |
| Address |  |
| Telephone number |  |
| Email |  |
| Preferred method of contact: |  |
| Any safety issues regarding contact? |  |
| Appointment type requested (face-to-face or telephone) |  |
| Date |  |

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| **Cultural background** | |
| Aboriginal |  |
| Torres Strait |  |
| Aboriginal and Torres Strait Islander |  |
| Culturally and Linguistically Diverse |  |
| Main language spoken at home? |  |
| Is an interpreter required? |  |

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| **Children’s information (if applicable)** | | | |
| Child’s name | Child’s date of birth | Father’s name | Current care arrangements |
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| **Main concerns** |

What are the main concerns in the client’s life at this time?

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| **Current supports in place (including both social and service based)** |

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| **Family and domestic violence/abuse** | |
| History of FDV |  |
| Current FDV |  |
| Safety/Risk Concerns |  |
| Current or previous AVO/court orders |  |
| FDV/Abuse post-separation |  |
| Current family/children’s court proceedings |  |
| Survivor and Children’s Strengths |  |
| Partner/ex partner’s name and date of birth (if applicable) |  |

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| **Mental health and alcohol or drug use** | |
| Current or previous self-harm or suicidality |  |
| Previous experiences accessing support |  |
| History of childhood trauma (only if previously disclosed) |  |
| Current or previous alcohol or drug use |  |

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| **Other relevant Information** |

Any areas that haven’t been mentioned in main concerns?