



*The referral will be discussed at our allocation meeting, please complete this form with as much information as possible, this will assist us to triage and lessens the need for clients to retell their stories.*

REFERRER DETAILS:			
Full Name:			Organisation:
Contact No:		Email:	
CLIENT DETAILS:			
First Name:			Surname:
Contact No:		Email:	
Address:			
Is it safe for us to: <b>Please tick the relevant options:</b>			
<input type="checkbox"/> Call <input type="checkbox"/> Leave a message <input type="checkbox"/> Text <input type="checkbox"/> Post to address listed <input type="checkbox"/> Email			
Date of Birth:		Gender Identity:	
CLIENT DEMOGRAPHICS:			
Does the client identify as Aboriginal or Torres Strait Islander?			
Does the client identify as LGBTIQ:			
CALD: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Country of Birth:			Year of Arrival:
Primary Language Spoken:		Does the client prefer to use an interpreter:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have any of the following impairments or disabilities?			
Are you homeless or at risk of being homeless?			
How would you describe the makeup of your household?			
Emergency Contact Name:			
Emergency Contact Phone No:			
Relationship to Client:			

Relationship status: **Please select from the following options:**

PARTNERS INFORMATION:			
Full Name:		Surname:	
Gender:		Date of Birth:	
Country of Birth:		Aboriginal or Torres Strait Islander:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usual place of residence:			

CHILDREN'S INFORMATION:					
First and Last Name	Gender	Date of Birth	Special Needs	Cultural Identity	Usual place of residence

What supports are you providing to this client and will this support continue following the referral?

Primary reason for referral and suggested supports:

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ISSUE	COMMENT
<b>Accommodation</b>	
<b>Does the client have somewhere safe to stay tonight:</b>	
<b>How long can the client stay there:</b>	
<b>Type of accommodation:</b>	
<b>Barriers to resolving own accommodation issues e.g. TICA</b>	
<b>Domestic Violence</b>	
<b>Please explain current risk and circumstances:</b>	
<b>Perpetrator details:</b> (Full Name and DOB).	
<b>Police involvement?:</b>	
<b>Date of last incident:</b>	
<b>AVO?:</b>	
<b>Mental Health</b>	
<b>Condition</b> (diagnosed or undiagnosed):	
<b>Treatment plan, if any</b> (including medication):	
<b>Treatment compliance:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Any current risk to self or others:</b>	
<b>Alcohol and Drugs</b>	
<b>Current substance use:</b>	
<b>Previous History:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, what substance:</b>	
<b>When was last use:</b>	
<b>Frequency:</b>	
<b>Dose:</b>	
<b>Any supports in place:</b>	

ISSUE	COMMENT
<b>Disability</b>	
<b>Intellectual:</b>	
<b>Learning Disorder:</b>	
<b>Psychiatric:</b>	
<b>Physical:</b>	
<b>Other:</b>	
<b>Any supports in place:</b>	
<b>Health</b>	
<b>Condition</b> (diagnosed or undiagnosed):	
<b>Current treatment plan, if any</b> (including medication):	
<b>Treatment compliance:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Financial</b>	
<b>Type of Income:</b>	
<b>Fortnightly amount:</b>	
<b>Client's next pay date:</b>	
<b>Any debts</b> (please list):	
<b>Child Protection</b>	
<b>Current concerns:</b>	
<b>DCJ involvement:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Family Law proceedings/orders:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

ISSUE	COMMENT
<b>Behaviour Concerns</b>	
<b>History of violence or aggressive behaviour</b> (If Yes, provide details):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Probation and Parole Involvement:</b>	
<b>Risk Taking Behaviour:</b>	
<b>Legal Issues</b>	
<b>Outstanding court appearances:</b>	
<b>Charges:</b>	
<b>Family Law:</b>	
<b>Are there any SAFETY concerns ?</b>	
<p>Please include any other relevant information</p>	

What other referrals have been made for this client?	
What other services is the client currently engaged with (include contact details if known):	
1.	
2.	
3.	

**You may obtain verbal or written consent from the client to make this referral. Please complete below.**  
*Please note, all services provided by Upper Hunter Community Services Inc. are **voluntary**.*

**Written consent from client:**

I, \_\_\_\_\_ consent for my information to be sent to Upper Hunter Community Services Inc. for the purpose of referral.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Verbal consent from client**

I, \_\_\_\_\_ (referrer) of \_\_\_\_\_ (agency) obtained the verbal consent of \_\_\_\_\_ (client name)

to collect, hold, and send his/her personal information to Upper Hunter Community Services Inc. for the purpose of referral.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**SUBMIT FORM**



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