Counselling Referral Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please email form to familycounsellor@gacc.org.au phone:9750 7982

Referral Agency Details:

Date Referred:	
Referral Agency:	
Referred By:	
Contact Phone & Email:	
Is Client aware of this referral?	

Client Details:

Client Name:	
Occupation:	
D.O.B:	
Address:	
Contact Number:	
Email:	
Gender:	
Country of Origin:	
Emergency Contact & phone number:	
Language/ Interpreter:	
Marital Status:	
Describe your general health. **Are you currently using medication?**	

Children Details:

First Name	Surname	M/F	DOB	Age	School/Childcare

Presenting Issues: (Please circle all that apply)

Mental Health	**Relationship Breakdown**	**Employment**
Domestic Violence	**Legal Issues**	**School/Education**
Housing	**Anger management**	**Parenting difficulties**
Grief/Loss	**Income Support**	**Family Concerns**

Other Concerns (not listed above)	
Brief description of how you would like assistance	
Other agencies or Services involved	
Any other relevant information?	
How did you hear about our Counselling/Casework service?	

Do you give us permission to contact any external organisations or agencies? Please give details.	

Thank you for your referral.

info@gacc.org.au p| 9750 7982 f| 9750-0850

Address: 3/159 Waterloo Rd, Greenacre

Postal Address: PO Box 164, Greenacre 2190