

Counselling Referral Form

Yorgum employs a team of counsellors to offer counselling and support within a case management framework to Aboriginal and Torres Strait Islander people who are affected by sexual abuse, family and domestic violence and grief and loss.

Yorgum offers creative options for culturally secure therapies whilst operating from a client centred perspective and from a trauma informed approach.

Client Details					
Client Name		Date of Referral			
Gender		Date of Birth			
Address		Contact number 1			
		Contact number 2			
Email					
Does the client have any disabilities?	Yes <input type="checkbox"/>			No <input type="checkbox"/>	
Language spoken at home		Interpreter required	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Aboriginal Status		
Aboriginal <input type="checkbox"/>	Torres Strait Islander <input type="checkbox"/>	Aboriginal & Torres Strait Islander <input type="checkbox"/>
Non-Indigenous with Aboriginal or Torres Strait Islander partner <input type="checkbox"/>		Non-Indigenous with Aboriginal or Torres Strait Islander children <input type="checkbox"/>

Parent/Guardian/Carer/Next of Kin Details			
Name		Relationship to client	
Contact Number		Email	

Agency Involvement		
Are there any other Services/Agencies involved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is counselling a mandatory requirement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Name of Person Making Referral			
Agency referral <input type="checkbox"/>		Self-referral <input type="checkbox"/>	
Name of person making referral		Agency	
Position		Relationship to person being referred	
Has this person (or their legal guardian) agreed to being referred to Yorgum?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Address		Phone	
		Mobile	
Email			

Reason for Referral		
Suicide & Self Harm <input type="checkbox"/>	Drug &/or Alcohol <input type="checkbox"/>	Child Sexual Abuse <input type="checkbox"/>
Family Violence <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Grief & Loss <input type="checkbox"/>

Signatures			
Applicant (Self)		Referrer (Agency)	
Name		Name	
Signature		Signature	

Parent or Legal Guardian of a child under 18	
Name	
Signature	

Please send this referral to Yorgum via the options listed below:

By Email	By Post
Please scan and email completed form to referrals@yorgum.org.au	Please post completed form to: Yorgum Aboriginal Corporation PO Box 236 Northbridge WA 6854

Once completed, the contents of this document are PRIVATE & CONFIDENTIAL.

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Yorgum Office Use Only	
Date referral received	
Date acknowledgment letter sent	
Allocated for action to	
Referral decision/follow up	