Yorgum Aboriginal Corporation
176 Wittenoom Street East Perth WA 6004
PO Box 236 Northbridge WA 6854
Phone: (08) 9218 9477 Fax: (08) 9221 0487
Email: referrals@yorgum.org.au
Website: www.yorgum.org.au

Referral Form

Clinical
□ Counselling
□ Children Experiencing Family Violence
□ Family or Domestic Violence
□ Physical, Emotional or Sexual Abuse Counselling
□ Advocacy
□ CBT

Link-Up
□ Link-Up and Family Tracing

Client	
Name:	Date of Birth:
Gender: □ Male □ Female □ Diverse Gender Identity □ Unknown	
Address:	Phone
	Mobile
Email:	Can we leave a voice message? □ Yes □ No

Aboriginal Status		
□ Aboriginal	□ Torres Strait Islander	□ Aboriginal & Torres Strait Islander
□ Non-Indigenous with Aboriginal or Torres Strait Islander partner		□ Non-Indigenous with Aboriginal or Torres Strait Islander children

Has this person (or their legal guardian) agreed to being referred to Yorgum?		□ Yes	□ No
Does the client have any disabilities?	□ Yes (*if Yes, please state*):		□ No
Language spoken at home:		Interpreter required: □ Yes	□ No

Name of Parent/Guardian/Carer/Next of Kin					
Name		Relationship		Mobile	
Phone		Can we leave a voice message?		□ Yes	□ No

General Health Information		
Do you suffer from any of the following?	□ Nut Allergy □ Bee/Wasp Allergy □ Epilepsy	□ Shellfish Allergy □ Asthma □ Diabetes
Any other medical conditions? (Please list)		
Have you previously been ***clinically*** diagnosed with a mental health condition?	□ Yes □ No □ Not Sure	If Yes, please list: _____

Agency Involvement			
Are there any other Services/Agencies involved?	□ Yes (*if yes, please list*)		□ No
Currently engaged with CPFS?	□ Yes	□ No	□ Unknown
Pending assessment with CPFS?	□ Yes	□ No	□ Unknown

Name of Person Making Referral			
□ Agency referral		□ Self-referral	
Name of person making referral	Relationship to person	Agency/Position (*if appropriate*)	
Address		Phone	
		Mobile	
Email			
Signature		Date of referral	

Are there any known risks to self/others/staff?	
□ Yes (*if yes, we will contact you for more information*)	□ No

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Primary Reason for Referral				
□ Suicide & Self Harm	□ Drug &/or Alcohol	□ Anger Management	□ Mental Health	□ Health
□ Family Violence	□ Grief & Loss	□ Child Sexual Abuse	□ Social/Family Issue	
□ Other (*please specify*)				

Background Information (*please attach further information to this form if required*)

By Email	**By Post**
Please scan and email completed form to referrals@yorgum.org.au	Please post completed form to: The Clinical Manager **or** The Link-Up Manager 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	