

Counselling Referral Form

Yorgum Healing Services employs a team of counsellors to provide counselling and support within a case management framework to Aboriginal and Torres Strait Islander people who are affected by trauma. 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"/>	
Is the client a carer for a person with disabilities?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Language spoken at home		Interpreter required	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Cultural Identify		
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"/>	Redress <input type="checkbox"/>
Family Violence <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Grief & Loss <input type="checkbox"/>	Disability Services (Royal Commission) <input type="checkbox"/>

THE REFERRED PERSON MUST SIGN THIS FORM.

Signatures			
Referred Person		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 Healing Services PO Box 236 Northbridge WA 6854

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

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