

## TERRITORIES STOLEN GENERATION REDRESS CLIENT REFERRAL FORM

Name:	DOB:
Phone (M):	Phone (H):
Address:	
Email:	
Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> (please specify) _____	Language:
Preferred contact method: Phone <input type="checkbox"/> Text/SMS <input type="checkbox"/> Email <input type="checkbox"/>	
Does the client have any disabilities? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Is the client a carer for a person with disability? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Aboriginal and/ or Torres Strait Islander Yes <input type="checkbox"/> No <input type="checkbox"/> Interpreter required Yes <input type="checkbox"/> No <input type="checkbox"/>	
If interpreter required, what language/language group?	

### REFERRER

Name and agency of person making referral:
Self-referral <input type="checkbox"/>
Referrers contact number:
Referrers email address:

### IF WE CAN'T CONTACT YOU IS THERE SOMEONE ELSE WE CAN TALK TO?

Name of assistant: (if client requested)	
Contact Number:	Client sign here:
Email:	

<b>Notes</b> (e.g. personal circumstances that may affect urgency of application)

### SIGNATURES – I UNDERSTAND AND GIVE CONSENT TO THE REFERRAL

Referred Person Name
Signature <span style="float: right;">DATE:</span>

Please attach any relevant supporting documents with this referral and send to Yorgum via the options listed below:

By Email	By Post
Scan and email the completed form and supporting documents to <a href="mailto:referrals@yorgum.org.au">referrals@yorgum.org.au</a>	Yorgum Healing Services PO Box 236 Northbridge WA 6854

Call 1800 469 371 any queries or visit us at 176 Wittenoom Street, East Perth WA 6004

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