TERRITORIES STOLEN GENERATION REDRESS
CLIENT REFERRAL FORM

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

REFERRER

Name and agency of person making referral:
Self-referral ☐
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:	

Notes (e.g. personal circumstances that may affect urgency of application)

SIGNATURES – I UNDERSTAND AND GIVE CONSENT TO THE REFERRAL

Referred Person Name	
Signature	DATE:

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 referrals@yorgum.org.au	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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