Counselling and Support Services (CASS) Referral form

womens health & family services

Date: _____

Client Details

Name:	**DOB:**
Phone (M):	**Phone (H):**
Address:	
Email:	

Preferred contact method: Phone call ☐ SMS ☐ Email ☐

Can we say we're calling from WHFS when contacting? Yes ☐ No ☐

Previous contact with WHFS? Yes ☐ No ☐

How did you hear about us? _____

Children: Yes ☐ No ☐ If yes, gender and ages? _____

Are they in client's care? Yes ☐ No ☐

Pregnant: Yes ☐ (number of weeks ____) No ☐

Interpreter needed? Yes ☐ No ☐ Preferred language? _____

Reason for Referral: _____

_____

_____

Other Relevant health, psychosocial, medical, treatment info: _____

_____

_____

Safety/Risk Factors: _____

_____

_____

Are you referring to a specific WHFS Counselling Service or Group?

If so please list: _____

Referral Information

External Provider ☐ Internal WHFS ☐ Self ☐

Referral Name & Organisation: _____

Contact details: _____(If internal, from which program?)

Consent (consent from the person being referred is required to make this referral)

I understand and give consent to the referral. ☐

I give permission for WHFS to obtain and release information to the person/ agency referring ☐

Signed: _____ Date: _____

Please send referrals to intake@whfs.org.au or fax 6330 5499

There may be fees for some services. We aim to make services accessible so please discuss with the Intake Officer.