FC17.1

REFERRAL to Sydney Women's Counselling Centre Thank you for referring your client. Please complete this form and send it to SWCC by:

mann you for referring your elients ricuse t	COIII	piece	this form and send it to sivee by.
Email: help@womenscounselling.com.au	or	Fax:	9718 7072
Phone: 9718 1955 for enquiries			

Your client will be contacted for	r further a	ssessment after	this form has be	en received.				
Referral Date:		Office use Only: S Presenting issues:	WCC Rego:	Intake date:				
ALL INFORMATION STRICTLY C	ONFIDENT	ΓIAL						
Referrer's Name:								
Organization:								
Telephone: Email:								
Client Details								
Name:								
D.0.B:								
Preferred Method of Contact: (Safe to co	ntact)						
Telephone: M	lobile:	Text only:						
Interpreter Required Yes /I	No	Language:						
Reason for Referral								
Are any of the following curr	ently pro	viding support/	services to the	person being referre	d?·			
Mental Health Services	YN	Psychiatrist	YN	GP	YN			
Family Services	ΥN	FACS	ΥN	Legal	YN			
Other:								
Any current Crisis/Safety issues								
Client Consent								
liaise with and to seek inforn concerning matters related t	nation pe o this app	rtaining to this plication.	referral from t	he referral source Date: / /				

 $\bullet \ \, \text{The Privacy Act requires the applicant or person responsible to sign this form giving their consent for the release of their information and details. SWCC will only use this information for its intended purpose. }$