REFERRAL FORM

REFERRAL TO:	Whitsunday Counselling and Support Inc. Shop 1, Cannonvale Square 157 Shute Harbour Road, Cannonvale Qld 4802 PH: 07 4946 2999				
Name of Agency:			Phone:		
Contact Person:			Email:		
CLIENT DETAILS:					
First Name:		Surname:		Date:	/ /
Age:		DOB:	/ /	Cultural ID:	
Gender:	☐ Female	☐ Male	☐ Non-binary	☐ Other	
Address:					
Phone:	(H)		(W)	(M)	
Safe to leave a voice message: ☐ Yes ☐ No			Safe to text: ☐ Yes ☐ No		
TYPE OF SERVICE REQUIRED:					
☐ Sexual Assault Counselling		☐ Parenting Support Programs		☐ DFV Court Support	
☐ Specialist Family Counselling		☐ Information, Advice & Referral		☐ DFV Counselling	
☐ IFS	☐ Women's Health & Wellbeing		☐ Community Programs (Love Bites, Circle of Security, Shark Cage)		
Relevant information: *(Please attach an extra sheet if needed)*					
CLIENT CONSENT:					
I,				(Client Name)	
give permission to				(Referring Agency)	
to refer me to Whitsunday Counselling and Support Inc. and provide them with my contact details and a brief description of the reason for referral. I understand that any information exchanged between the two agencies on this form will be kept confidential and that Whitsunday Counselling and Support Inc. will contact me to organize an appointment for support services that I require.					
Client Signature:		Referring Agency Signature:			
Please email completed referral form to: intake@whitsundaycs.com.au					

OFFICE USE ONLY					
Referral accepted: ☐	Worker allocated:		Initial Appointment Date:	/ /	
Referral not accepted: ☐	Reason:				
Outsourced referral to:					