

# Link HC - Family Services Counselling & Paediatric Psychology Referral Form

Phone: 1300 552 509

Fax: 03 9563 2893

Email: [linkhc@linkhc.org.au](mailto:linkhc@linkhc.org.au)



## Date of Referral:

### Consent:

Yes -  Consumer consents for referral and information to be given to relevant persons  
No -  Consumer does not give consent

### Consumer Details:

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  male /  female

Child Lives with: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone/Mobile: \_\_\_\_\_

Can we leave a message/send a SMS?  Yes /  No

Can we send information about our services?  Yes /  No

Do you have a Healthcare card?  Yes /  No

Card Number: \_\_\_\_\_ Exp: \_\_\_\_\_

### Indigenous Status:

Aboriginal /  Torres Strait Islander

Both Aboriginal & Torres Strait Islander

NOT Aboriginal or Torres Strait Islander

### Childcare / Kindergarden / School Details:

School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/email/fax: \_\_\_\_\_

School Teacher/s: \_\_\_\_\_

Year Coordinator/Welfare/Counsellor: \_\_\_\_\_

### Referral Details:

Referring Person: \_\_\_\_\_

Organisation: \_\_\_\_\_ Position: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

### Reason for Referral:

(What is happening? How does this impact on the client?)

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### Family Background / Issues / Factors:

(Is there any history of mental or physical health conditions? Are there any stressful events that have occurred? Are there any legal matters?)

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### Professional Assistance:

(Has the client seen a counsellor/psychologist in the past? What issues were addressed? Are there any other agencies/professional services currently involved?)

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### Alerts:

(Are there any known risks to the clients or staff?)

Yes  No  Unsure

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**1300 552 509**

[www.linkhc.org.au](http://www.linkhc.org.au)