**WOMEN’S WELLBEING PROGRAM**

**REFERRAL FORM – External**

Email to: womensspace@laurelplace.com.au

**REFERRAL SOURCE**

**Date of referral:**

**Referring Agency & Contact Person:**

**Phone No:** **Email:**

**CLIENT DETAILS**

**Name of Client:** **DOB:**

**Preferred Name:**

**Address:**

**Mobile:**

**Email:**

**Gender: Female** [ ]  **Male** [ ]  **Non-binary** [ ]  **Different Term** [ ]   **Prefer not to state:** [ ]

**Does Client identify as a First Nations person**? YES [ ]  NO [ ]

**Indigenous Status:** [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Not stated

**Does Client identify as Culturally and Linguistically Diverse?** YES [ ]  NO [ ]

**Identified cultural background:**

**Interpreter required:** NO [ ]  YES [ ]  **Language:**

**Does the client experience a disability or impairment?** NO [ ]  YES [x]

If yes, please provide details if available:

**HISTORY OF GENDER-BASED VIOLENCE**

**CONSENT**

**Is the client aware a referral has been made to Laurel Place? Yes** [ ]  **No** [ ]

**Has the client consented to be contacted by Laurel Place? Yes** [ ]  **No** [ ]

**Safe to leave voicemail Yes** [ ]  **No** [ ]  **Safe to send SMS: Yes** [ ]  **No** [ ]

**Safe to email Yes** [ ]  **No** [ ]

[ ]  Domestic and Family Violence [ ]  Sexual Assault [ ]  Other:

Is there a current DVO in place? NO [ ]  YES [ ]

Family Court Orders? NO [ ]  YES [ ]

Contact with perpetrator? NO [ ]  YES [ ]

If yes, please provide details if available:

**CURRENT SAFETY/RISK FACTORS IDENTIFIED**

**Is the client currently safe?** YES [ ]  NO [ ]  *If no, please refer to emergency services or the regional domestic violence service.* ***If yes please attach safety plan and or risk assessment with referral****.*

**Is Child Safety involved?** NO [ ]  YES [ ]

If yes, please provide details:

**Does the client experience:**

Suicidal ideation No [ ]  Yes [ ]  Historical ☐

*(\*Please note –Laurel Place is not a crisis service. If immediate risk is identified, please refer to emergency or acute services).*

Self-harm No [ ]  Yes [ ]  Historical ☐

Harm to others No [ ]  Yes [ ]  Historical ☐

Substance Use No [ ]  Yes [ ]  Historical ☐

Other mental health concerns No [ ]  Yes [ ]

***If yes to any of the above, please provide details:***

**REASON FOR REFERRAL**

*Please provide us some details on brief history of DFV, suitability and readiness for DFV counselling etc.*

**CURRENT SUPPORTS**

*Please provide list of current and past supports e.g. DFV services, CSO, psychologists, mental health team and please provide details on support relevant services have provided.*

**OTHER RELEVANT INFORMATION**

*Please provide any other relevant information including details of children, current living arrangements, details of court matter’s such as FLC or DV court.*