**WOMEN’S WELLBEING PROGRAM**

**REFERRAL FORM – External**

Email to: [womensspace@laurelplace.com.au](mailto: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

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.*