interrelate®
relationship experts since 1926

REFERRAL TO INTERRELATE

Address:		**Phone:**	
Email:		**Fax:**	

Date of Referral		**Referrer's Name and Position**	
Referring Organisation			
Phone:		**Email:**	

Primary Client Details

Name		**D.O.B**	
Phone		**Able to leave message?**	☐ Yes ☐ No
Address			
Email		**Preferred method of contact**	
Aboriginal or Torres Strait Islander?	☐ Yes ☐ No	**CALD?**	☐ Yes ☐ No
		Nationality?	
		Language/s spoken at home?	
		Interpreter required?	☐ Yes ☐ No
Any special needs?	☐ Yes ☐ No	**Details**	
Is client aware the referral is being made?	☐ Yes ☐ No	**Client Signature**	
Does the client consent to being contacted by Interrelate?	☐ Yes ☐ No		

Other Client Details – (If primary client is under 18yrs – please put parent's/guardian's details here)

Name		**D.O.B**	
Phone		**Relationship to primary client**	
Address			
Email			

Child/ren Details

Name/s		**D.O.B/s**	

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Legal & Safety Needs	Yes/No	Details (Attach documents if referrer has a copy)
History of DV	☐ Yes ☐ No	
AVO	☐ Yes ☐ No	
Court Orders	☐ Yes ☐ No	
FACS involvement	☐ Yes ☐ No	
Mental Illness/ Suicidality	☐ Yes ☐ No	
Other safety?	☐ Yes ☐ No	

Other agencies working with this client / family	
Name of agency, worker, contact details and purpose of support	
Name of agency, worker, contact details and purpose of supportworker, contact details and purpose of support	

Reason for seeking assistance / presenting concerns?
E.g. Relational difficulties, mental health, safety etc. What outcomes would the client like to achieve?

Categories / Program Type requested

- ☐ Counselling – Individual/ Couples / Family / Children
- ☐ Group/s
- ☐ Royal Commission Community Based Support Service
- ☐ Building Stronger Families / Post Separation Cooperative Parenting (Case Management)
- ☐ Children's Contact Service– Supervised Contact / Change Over – Change Back
- ☐ Mediation / Family Dispute Resolution
- ☐ Family Mental Health Support Service
- ☐ Personal Helpers and Mentors Scheme
- ☐ Specialised Family Violence Case Management
- ☐ Respectful Man Program

Date contact made with client and details

Summary of Referral / Notes / Comments / Any specific supports required

Referral Outcome

☐ **Referral accepted – Appointment offered**

Appt. Date		Time		Practiotioner	
☐ **Referral not accepted**		**Reason**			

☐ **Client declined referral**

Referral outcome communicated to referring agency

To		Date		By	