**CLIENT DETAILS Date of Referral:…………………………………………**

|  |  |  |
| --- | --- | --- |
| Name of client |   | Aboriginal Torres Strait Islander Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB Age  |   |
| Gender |  |
| Address  |  |
| Client contact number |  |
| Parental /carer details  |  |
| Parental/carer phone number |  |
| Parental/carer email |  |

 **REFERRING AGENCY DETAILS**

|  |  |
| --- | --- |
| Referring agency |  |
| Contact person |  |
| Phone  |  |
| Email  |  |
| Reason for referralpresenting issues |  |
| Services provided by Referring agency to date |  |
| Risk alerts to self or others(Including AOD, mental health, self harm, suicide ideation) |  |
| Other services involved with the client |  |

**PROCESS OF REFERRAL**

|  |  |
| --- | --- |
| Does the client know that the referral has been made? | **YES - NO** |
| Is the clients parent/carer willing to give consent for the young person to work with Balunu? | **YES - NO** |
| Do we have permission to make contact with the young person? | **YES - NO** |

**Please forward this referral form to Noeletta McKenzie - Manager**

**noeletta.mckenzie@balunu,org.au**

Phone: (08) 89854400

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