**Client information**

|  |  |
| --- | --- |
| **Given Name:**  | **Surname:**  |
| **Preferred name:**  | **Gender:**  |
| **Date of Birth:**  | **Country of birth:**  |
| **Address:**  |
| **Client Phone Number:**  | **Email address:**  |
| **Emergency contact Name:**  | **Phone:**  |
| **Relationship:**  |
| **Allergies:**  |
| **Special access or communication requirements:**  |
| **Funding source** (if applicable)  |
| **Is an interpreter required Y / N What language?**  |
| **Please provide any information about disability, chronic medical or mental health condition?**  |
| **What mental health concerns or recent events have prompted you to make this referral?**  |
| **What are the person’s goals for therapy?**  |
| **Are there any other mental health professionals involved in this person’s care? Y / N**\* please read accompanying document information for clients. |

Referrer Information

|  |  |
| --- | --- |
| **Name of referrer:**  | **Will you continue to work with the person? Y/N** |
| **Relationship to client:**  |
| **Referrer Contact:**  |
| **I Declare that the above mentioned client is aware of this referral and consents to providing this information.** |
| **Signed:**  | **Date:**  |
| **Name:** |

Please send the completed form to

**kate@pelicanarts.com.au**

**or**

**PO Box 719 Mildura Vic 3502**

**Once received we will acknowledge the referral either by telephone or e-mail**

**We will contact the client to discuss the referral within one week.**

**We will then add the client to our waitlist.**