1. **Client details:**

Date: Name: Preferred name:

Date of Birth \_\_\_\_\_ ­ /\_\_\_\_­ /\_\_\_\_\_\_ ­ Age: Gender:

Address:

Suburb: Postcode: State:

Home Ph: Mobile:

Which contact is preferable for us to use? ☐ Home ☐ Mobile

Does the client give permission to leave a message? ☐ No ☐ Yes

Medicare card number: Reference No: Expiry date:

Next of Kin (i.e. family member, significant other)

Name: Phone: Relationship to client:

In Case of Emergency Contact (i.e. best friend, trusted family friend)

Name: Phone: Relationship to client:

If under 16, are the parents / carers aware of this referral? ☐ No ☐ Yes

1. **Referrer details:**

Contact Name: Organisation (if applicable):

Position / Relationship: Fax:

Phone: Mobile: ­

Is the young person aware of this referral? ☐ No ☐ Yes

1. **Reason for referral:**

Are there any known risks to the young person/ others/ staff? ☐No ☐ Yes. If yes we may contact you for further information