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AGENCY REFERRAL FORM

This form is to be completed by the Referrer/Agency Department

THIS FORM IS CONFIDENTIAL and must be agreed by the client that the details set out on this referral form are accurate.

Please print form. Fill out and fax on number indicated above.

A confirmation email of acknowledgement will be sent to the referrer.

Please be aware that Community Counselling and Care is not a crisis service. Please ring 131465 (Adult MH 24hr Support) or 000 (Ambulance) if required.

Name of Client: _____

Address of Client: _____

Telephone of Client: _____

Date of Birth: _____ / _____ / _____

Gender: Male ☐ Female ☐ Marital status: Single ☐ Married ☐

Name of the organisation referring: _____

Address and phone number of referring organisation_____

Name of the person referring behalf of the organisation: _____

Date of Referral _____/ _____ /_____

Issues identified

_____

Are there any other areas of concern that require support? Risk factors?

_____

Details of GP

Name of GP _____

Practice name and address _____

GP Contact no. _____

Does the referred client require follow up by CC&C to be assisted with the referral process (gaining a mental health care plan etc.)?

Yes ☐ No ☐

Has a Mental Health Care Plan already been obtained from the GP? (for non-contracted services)

Yes ☐ No ☐

Does the referrer need to be notified of the outcome (pending client permission)?

Yes ☐ No ☐

If yes, please provide an email address of referrer_____

Thank you for your referral.

Community Counselling and Care is committed to a quality, friendly and affordable service.
Please do not hesitate to contact me should you require any further information or assistance.

Kind regards
Daniel Wakefield
Managing Director & Mental Health Clinician
Community Counselling & Care
ABN: 86606788685