COUNSELLING AND SUPPORT
LIFE CHANGING

HOLYOAKE
FAMILY • INDIVIDUALS • YOUTH

Contact Details
Phone: 9416 4444
Fax: 9416 4443
Clientservices@holyoake.org.au

LFM: Referral to Holyoake Individual & Family Services

Referrer's Details				
Referring Person			Job Title	
Organisation				
Contact Details	E-mail		Phone	
Date of Referral				

Client Details					
First Name			Last Name		
Date of Birth		Age		Circle Female Male Other	
Residential Address					
Telephone Numbers	Mobile		Home		Work
Country of Birth		Circle Aboriginal TSI CALD		Interpreter Required	Circle Yes No
Own Use	Circle Yes No	Other's Use	Circle Yes No	Relation to User	

Substance Use					
Substance	**Tick**	**Amount Used**	**Frequency Of use**	**Duration of Use**	**Additional Information**
Alcohol					
Cannabis					
Methamphetamines					
Amphetamines					
Heroin					
Other Opiates					
Hallucinogens					

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Identified Risks in Working with the Client					
History of Aggression/Violence	Yes	No	Currently Pregnant	Yes	No
History of Self-harm/Suicidality	Yes	No	Positive for BBV	Yes	No
History of Unsafe Injecting Practice	Yes	No	Currently Lives Alone	Yes	No
Restraining Order	Yes	No			

Current Medical/Mental Health Problem(s) and Prescribed Medication(s)

Other Agencies Involved **(please complete attach completed release of information)**

Reason For Referral

Authority to Release and Obtain Information

I [please print full name], ……..

of ……..…….
[please print current address]

hereby consent to Holyoake releasing and obtaining reports and information as specified below:

Person	Agency	Address	Information
……..	……..	……..…	……..……
……..	……..	……..…	……..……

SIGNATURE:..……..……..

WITNESS: ……..……..

Please Print Full Name of Witness: ……..……

DATE: ……/..……/ ..……