STARTTS - REFERRAL FOR COUNSELLING

CONFIDENTIAL

Please send this form by EMAIL to: STTS-IntakeGeneral@health.nsw.gov.au
by Phone : (02) 9646 6800
or FAX to: (02) 9646 6801

Items marked * are important to our referral processes. If the item is unknown or not applicable, please specify as such.

CLIENT DEMOGRAPHICS

DIBP ID:	**Agency Client ID:** *(your reference number if you have one)*		**Referral Date:**
***Family Name:**	***Given Name:**	***Gender:** ☐ Male ☐ Female	***DOB:**
***Telephone Number (Main):**	**Telephone Number (Other):**	**Email:**	
***Address of Usual Residence:**		***Suburb:**	***Postcode:**

Marital Status: ☐ Never Married ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widow ☐ Unknown

***Country of Birth:**	***Preferred Language:**	***Interpreter Required:** ☐ Yes ☐ No	
Ethnicity:	**Religion:**	***Interpreter Gender Preference:** ☐ Male ☐ Female ☐ Either	***Counsellor Gender Preference:** ☐ Male ☐ Female ☐ Either

PERSON TO CONTACT

Name:	**Relationship to Client:**		
Address of Usual Residence: *(if the same as client, please write 'as above')*		**Suburb:**	**Postcode:**
Telephone Number (Main):	**Telephone Number (Other):**	**Email:**	

RESIDENTIAL / VISA INFORMATION

***Residential Status:**
☐ Australian Citizen ☐ Permanent Resident ☐ Temporary Visa Holder ☐ Asylum Seeker ☐ Unknown

***Date of Arrival:**	**Visa Subclass:**	**Asylum Seeker Category:** ☐ ASAS ☐ CAS ☐ CD ☐ IDC ☐ Unknown	
***Date of Protection Visa Grant:**	**Detention in Australia:** ☐ Yes ☐ No	**Place:** 1. _____ 2. _____	**Duration (months):** _____ _____

REFERRER DETAILS

***Name:**	***Organisation:**		
Address:		**Suburb:**	**Postcode:**
***Telephone Number (Main):**	**Telephone Number (Other):**	**Fax Number:**	
Email:			

CONSENT FOR REFERRAL

***Has the client or the client's parent / guardian consented to this referral?** ☐ Yes ☐ No

Referral Number: Office use only	**Medical Record Number:** Office use only

BINDING MARGIN - NO WRITING

REFERRAL FOR COUNSELLING

FORM A1

Rev June 2018

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FOR CHILD / ADOLESCENT CLIENTS ONLY

School Name:	**Suburb:**	**Year/Class:**

Person to Contact at School:	**Telephone Number:**

Position:

☐ Classroom teacher ☐ ESL Teacher ☐ School Counsellor ☐ Other, *please specify:* _____

REASONS FOR REFERRAL

***Main presenting problem(s) and symptoms (if known):**

_____

_____

_____

_____

***History or presence of the following issues (please specify further in the space provided):**

Past	Current	Unknown	
☐	☐	☐	Torture or refugee trauma
☐	☐	☐	Physical health issues and/or disabilities
☐	☐	☐	Intervention from a mental health crisis team
☐	☐	☐	Admission to hospital because of mental health issues
☐	☐	☐	Suicidal ideation and/or attempts
☐	☐	☐	Drug and/or alcohol use
☐	☐	☐	Domestic violence
☐	☐	☐	Sexual assault

Please specify: _____

_____

_____

For child/adolescent clients only:

Past	Current	Unknown	
☐	☐	☐	Parents/carer issues (e.g. marital problems, financial difficulties, mental health)
☐	☐	☐	Child / young person risk of harm and/or child protection concerns

Please specify: _____

_____

_____

Does the client have any current support network? ☐ Yes ☐ No *Please specify:* _____

_____

STARTTS OFFICE USE ONLY

Client Category: ☐ HSS ☐ Non HSS	**Summary for Prioritisation:** ☐ Age ☐ Single Parent ☐ Disability ☐ Physical Health ☐ Family Issues ☐ Interpreter ☐ Torture & Trauma ☐ Symptoms ☐ Mental Health ☐ Support Network

Priority Status:	**Date Priority Assessed:**

Date Allocated:	**Allocated to:**	**Date Re-Allocated:**	**Re-Allocated to:**

Date Letter to Referrer Sent:	**Date Letter to Client Sent:**	**Date of First Appointment:**

Comments: _____

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