Self Referral Form

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| Do you give permission for PCL to collect and store your information for the purposes of providing support to you and reporting to our funding body? Yes  No  *(If no – cease completion of form)*  DATE OF REFERRAL :      CLIENT NAME:  DATE OF BIRTH:       ADDRESS:  PHONE NUMBER:      EMAIL ADDRESS:    GP (Name & Contact Number):  (*PCL requires access to GP if providing mental health support)*    **Please tick all that applies:**  **Do you require the use of an interpreter?**  **Do you require a support person to be present?**  **Are you Aboriginal or Torres Strait Islander?**  **What is your country of birth?**  **Mental Health Screen:**  **Are you currently seeing a Psychiatrist or Counsellor?** Yes  No *(If yes – please provide details below)*    **Do you have a current mental health Care Plan?** Yes  No *(If yes – please provide details below)*    **Do you have any current concerns about your mental health?** Yes  No *(If yes – please provide details below)*    **Are you experiencing any suicidal thoughts, feelings or actions?** Yes  No *(If yes – please provide details below)*    **Are there any safety issues within your relationship?** Yes  No *(If yes – please provide details below)*    **Do you have any concerns about alcohol or substance use?** Yes  No *(If yes – please provide details below)*    **Would you like to be placed on PCL’s Needs Register/Waitlist for Counselling if we are unable to offer you an immediate service?** Yes  No |

**Reason for Referral**: *(please select from drop down items)*

**Is there any other Information PCL should know about you?**

***Thank you for your referral – A Counsellor will be in touch to advise you of the outcome as soon as possible.***

**PCL OFFICE USE ONLY: Counsellor Allocated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Needs Register**

**ACTION/INTAKE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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