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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