**Referral to Pregnancy Counselling Link (PCL)**

*(This form may also be used by a referring organisation)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you (or the person you are referring) give permission for PCL to collect and store personal information for the purposes of providing support and reporting to our funding body?  *(If no – please cease completion of this form)* | | | | | | | | | | | | Yes | | |  | |
| No | | |  | |
| **Date:** |  | | | | | | | | | | | | | | | |
| **Name (client):** |  | | | | | | **Date of Birth:** | |  | | | | | | | |
| **Contact phone number (client):** | | |  | | | | | | | | | | | | | |
| **Email address (client):** | |  | | | | | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
| What is your/the client’s country of birth? | | | | | |  | | | | | | | | | | |
| Do you/the client identify as Aboriginal or Torres Strait Islander?  *If yes, please specify:* | | | | | | | | |  | | | | | | | |
| Is an interpreter required to assist you/the client if we undertake individual or group counselling? | | | | | | | | | | | | |  | | | |
| Are there any current mental health concerns? | | | | | | | | Yes | |  | No | | |  | | |
| Are there any safety concerns within your/the client’s relationships? | | | | | | | | Yes | |  | No | | |  | | |
| Are any services currently supporting you/the client? | | | | | | | | Yes | |  | No | | |  | | |
| Is a support person required to attend sessions with you/the client? | | | | | | | |  | | | | | | | | |
| **What is the reason/s for seeking support from PCL?** *(please tick all that apply)* | | | | | | | | | | | | | | | | |
| Pregnancy Options | | | |  | Pregnancy Loss or Grief | | |  | Infertility | | | | | | |  |
| Transition to parenthood/parenting | | | |  | Relationships | | |  | Group program participation | | | | | | |  |
| Pregnancy Support | | | |  | Mental Health | | |  | Other *(please specify)* | | | | | | |  |

Please provide any other relevant information:

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| --- | --- | --- | --- | --- | --- |
| **PCL has a waiting list for ongoing support. Do you consent to being placed on our wait list until a Counsellor becomes available?** | Yes |  | No |  | |
| **If PCL attempts to contact you, is it ok for us to leave a message/text your mobile phone?** | Yes |  | No | |  |

***PCL will contact you/the client to complete an Intake Interview (approx. 20 mins) to determine eligibility for our service.***

***Please complete this section if you are an Agency referring this client***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Agency Name: |  | | | | | |
| Agency Contact: |  | Contact Number: |  | | | |
| Is the client aware of this referral? | | | Yes |  | No |  |