



CLIENT REFERRAL FORM

Date of Referral: _____

Type of referral: Outreach Counselling Shelter

Other: _____

Please note the following: Emergency relief days are Monday, Wednesday & Thursday from 10am-2pm

- All requests for Emergency Relief must present a current Income Statement to be eligible.
- NWS will not accept any person/s into the shelter under the influence of any substances.
- NWS staff will need to speak to clients to assess their needs prior to intake.

Referring Agency: _____ Workers Name & position: _____

Client's Name: _____

DOB: _____ / _____ / _____ Gender: F M

Ethnicity: Indigenous - local or Transient (Please circle) Torres Strait Islander

Both Other: _____

Relationship status: Married De-facto Single Divorced Separated

Current Address: _____

Phone #1 _____ CRN# _____

Does the client have any medical needs NWS should be aware of:

Is the client on any medication? If so, please list type of medication and frequency:

Is the client experiencing / presenting any of the following issues? YES / NO

Substance Abuse

Sexual Assault / Abuse

Other: _____

Mental Health

Family & Domestic Violence

Circumstances leading to referral:

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Client's Consent for the organisation to collect, store and share information collected from the client for organisational purposes (Tick relevant box) Yes No

If no is selected what is the reason? _____