**ADOLESCENT & FAMILY COUNSELLING PROGRAM**

**CLIENT REFERRAL FORM**

**Phone: 9646 2122 - 9749 2321**

**Email:** [**jean@ayc.org.au**](mailto:jean@ayc.org.au)

**CLIENT INFORMATION**

Date of Referral:……………………………………………………………………………………………………………………….

First Name:………………………………………………………………………………………………………………………………

Surname:…………………………………………………………………………………………………………………………………

DOB:…………………………………………………………………………………………………………………………………………

Age:…………………………………………………………………………………………………………………………………………..

Gender: M F Other

Address:…………………………………………………………………………………………………………………………………...

Relationship status: ……………………………………………………………………………………………………………………….

Employment/study: ………………………………………………………………………………………………………………………

Phone:……………………………………………………………………………………………………………………………………...

Do you identify as Aboriginal and/or Torres Strait Islander?..............................................................

Country of Birth:………………………………………………………………………………………………………………………

Time in Australia:…………………………………………………………………………………………………………………….

Language(s) spoken at home: ……………………………………………………………………………………………………

Interpreter Required: Yes No

Is the young person aware of the referral being made? Yes No

Are the parent(s)/guardian(s) aware of the referral? Yes No

Any medical/health issues?...................................................................................................................

Any medications/substances taken?……………………………………………………………………………………………

Any Legal/Police Issues?

Please list and/or Describe…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**PARENT/GUARDIAN/OTHER**

Name:………………………………………………………………………………………………………………………………………

Relationship:…………………………………………………………………………………………………………………………...

Address:…………………………………………………………………………………………………………………………………….

Contact Phone:………………………………………………………………………………………………………………………..

**REFERRER INFORMATION**

Name of Referrer: ……………………………………………………………………………………………………………………….

Referring Agency: ………………………………………………………………………………………………………………………...

Address: ………………………………………………………………………………………………………………………………………

Contact number: …………………………………………………………………………………………………………………………...

Reason for referral………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………