Women's Health Information and Referral Service Central Queensland Inc.
Location: 225 Bolsover Street, Rockhampton **Mailing Address:** PO Box 472 Rockhampton QLD 4700
Phone: 4922 6585 or 1800 017 382 **Email:** reception@whccq.org.au
Web: www.womenshealthrockhampton.com

CLIENT REFERRAL FORM

The Women's Health Information and Referral Service CQ aims to enhance women's quality of life by providing a holistic service, contributing to the empowerment of individuals and improving the health and well-being of all throughout Central Queensland.

The WHIRS works from a feminist perspective, which values all individuals, acknowledges diversity and provides an individual focussed model of service delivery. We encompass strength-based philosophies, which encourage an open honest and transparent therapeutic relationship with clients.

Eligibility Criteria

- Counselling, information & referral for emotional health & wellbeing
  (E.g. personal, family and relationships, historical domestic violence) ***women from 12 years and over***
- Sexual violence counselling and support service - ***women, men & youth from 12 years and over***
  (recent or historical)

Have you discussed this referral with the client and they have agreed to information being shared with WHIRS?

Yes ☐ If not, please stop this referral process		Date:	
Referring Person / Agency:			
Agency's Postal Address:			
Agency's Contact Phone:		Fax:	

Client Name:		DOB:	
Phone Home:	Is it ok to leave a message ☐Y ☐N		
Phone Work:			
Phone Mobile:	Is it ok to leave a message ☐Y ☐N		
Email:			
Preferred method of contact:	☐ Mobile ☐ Text ☐ Email ☐		
Residential Address:		Is it ok to send correspondence to this address ☐Y ☐N	
Emergency Contact Name:			
Relationship to client:		Phone:	

Please read this section to client:
This may be a difficult question for you to answer; however providing an answer will ensure you are prioritised correctly.

Have you been affected by sexual assault? ☐Y ☐N
If you answered yes to this question was it recent within the last two weeks. ☐Y ☐N ☐Historical
Is this an issue that you would like to discuss ☐Y ☐N ☐Unsure

Cultural Background: (for statistical purposes only)

☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander ☐ CALD ☐ None of these apply

Client Status: ☐ Employed ☐ Unemployed ☐ Concession Card Holder

Client Group: ☐ Refugee ☐Disability ☐ Homeless ☐ Overseas Visitor ☐ Student ☐ Other

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Is the client engaged in services/supports from other organisations (i.e. Mental Health, Psychologist, and/or Community Program)?

Organisation Name	Date Commenced	Contact Name	Contact Number

Brief description of circumstances/ other information: _____

_____

_____

_____

_____

_____

_____

Preferred day / time for appointment: _____

Preferred method of counselling: ☐ Face-to-Face / Phone ☐ Face-to-Face ☐ Phone

Referral origin type:

☐ Self ☐ Self/Previous client ☐ GP/Medical

☐ NGO ☐ Government ☐ Other

If other: _____

Consent to release client information- must be fully completed to disclose ANY information.

Read to Client: WHIRS is unable to provide ANY information to any party without your explicit consent. You can change, reverse or add to these permissions at any time by speaking to your counsellor. If you wish for any details to be shared please complete the details below:

I, _____ (client name) give my consent for Women's Health Information and Referral Service CQ Inc. to release information with the following persons and/or agency

_____ regarding:

☐ Appointments (to make appointments on my behalf, check next appointment, cancel and/or change)

☐ Engagement (to ask if I am attending my appointments and level of engagement)

☐ Content (to be able to ask detailed information about the content discussed in my session

NOTE: any request will be discussed with you prior to information being released.)

_____ _____

Client signature Date

Where did you hear about the WHIRS CQ service? _____

Please forward the completed referral form to intakeofficer@whccq.org.au