



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 Inc. (WHIRSCQ) 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 WHIRSCQ works from a feminist perspective, which values all individuals, acknowledges diversity, and provides an individual-focused service delivery model. 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 and youth 14 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 WHIRSCQ?		Date:	
Yes <input type="checkbox"/> If not, please stop this referral process			
Referring Person / Agency:			
Agency's Postal Address:			
Agency's Contact Phone:		Fax:	

Client Name:			
Date of Birth:			
Phone Home:	Is it ok to leave a message <input type="checkbox"/> Y <input type="checkbox"/> N		
Phone Work:			
Phone Mobile:	Is it ok to leave a message <input type="checkbox"/> Y <input type="checkbox"/> N		
Email Address:			
Preferred method of contact:	<input type="checkbox"/> Mobile <input type="checkbox"/> Text <input type="checkbox"/> Email		
Residential Address:		Is it ok to send correspondence to this address? <input type="checkbox"/> Y <input type="checkbox"/> N	
Emergency Contact Name:			
Relationship to client:		Phone:	

PLEASE READ THIS SECTION TO THE 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?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
If you answered yes to this question, was it within the last two weeks?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Historical
Is this an issue that you would like to discuss?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unsure

Our Mission is to Support ❖ Create ❖ Share

Women's Health Information & Referral Service CQ Inc. ABN 63 464 913 092

Funded by: Queensland Department of Justice & Attorney-General



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FOR STATISTICAL PURPOSES ONLY:						
Identified Gender:		<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Non-binary	<input type="checkbox"/> Prefer not to say	
Do you identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual or plus? <input type="checkbox"/>						
Cultural Background:						
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> South Sea Islander	<input type="checkbox"/> CALD	<input type="checkbox"/> None of these apply		
Client Status:		<input type="checkbox"/> Employed		<input type="checkbox"/> Unemployed		<input type="checkbox"/> Concession Card Holder
Client Group:		<input type="checkbox"/> Refugee	<input type="checkbox"/> Disability	<input type="checkbox"/> Homeless	<input type="checkbox"/> Overseas Visitor	<input type="checkbox"/> Student <input type="checkbox"/> Other

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:

- | | | |
|-------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Self | <input type="checkbox"/> Self/Previous client | <input type="checkbox"/> GP/Medical |
| <input type="checkbox"/> NGO | <input type="checkbox"/> Government | <input type="checkbox"/> Other |

If other: _____

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

Read to Client:

WHIRSCQ cannot provide ANY information to any party without your explicit consent. You can change, reverse or add to these permissions anytime 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 ask for detailed information about the content discussed in my session).

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

Client Signature

Date

Where did you hear about the WHIRSCQ service? _____

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

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