**CLIENT DETAILS** Date of Referral:…………………………………………

|  |  |  |
| --- | --- | --- |
| Name of client |  | Aboriginal  Torres Strait Islander  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB  Age |  |
| Gender |  |
| Address |  | |
| Client contact number |  | |
| Parental /carer details |  | |
| Parental/carer phone number |  | |
| Parental/carer email |  | |

**REFERRING AGENCY DETAILS**

|  |  |
| --- | --- |
| Referring agency |  |
| Contact person |  |
| Phone |  |
| Email |  |
| Reason for referral/presenting issues |  |
| Services provided by  Referring agency to date |  |
| Risk alerts to self or others  (Including AOD, mental health, self  harm, suicide ideation) |  |
| Other services involved with the client |  |

**PROCESS OF REFERRAL**

|  |  |
| --- | --- |
| Does the client know that the referral has been made? | **YES - NO** |
| Is the clients parent/carer willing to give consent for the young person  to work with Balunu? | **YES - NO** |
| Do we have permission to make contact with the young person? | **YES - NO** |

**Please forward this referral form to Noeletta McKenzie - Manager**

[**noeletta.mckenzie@balunu,org.au**](mailto:noeletta.mckenzie@balunu,org.au)

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