



Client Referral & New Issue Form

Please give, send, fax or email to Therapy ACT. For current Therapy ACT clients with new issues, please forward to their current therapist.

PLEASE PROVIDE THE FOLLOWING CLIENT INFORMATION:		Date of Referral:	
Name:		<input type="checkbox"/> Female	<input type="checkbox"/> Male
DOB:		Indigenous Status:	
Country of Birth:		<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander
Living Arrangements: (e.g. with family, group home)		<input type="checkbox"/> Aboriginal & Torres Strait Islander	
		<input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander	
Address:			
Home Ph:		Mobile:	Other:
Email:			
Preferred Language:		Interpreter Required?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis: (if known)			
Education Setting: (if appropriate)		Class:	
Medications: (if known)			
Therapy ACT Services: (please provide details)			
Past:			
Present:			
Other Relevant Agencies Involved:			

ESSENTIAL INFORMATION

Please provide Parent/Guardian details

Name 1: Relationship to client:		Name 2: Relationship to client:	
Address: (if different from above)		Address: (if different from above)	
Home Ph:	Work Ph:	Home Ph:	Work Ph:
Mobile:	Email:	Mobile:	Email:

Name of Client:	DOB:
Reason for Referral: (please describe in detail)	

Strategies that have been trialled, previously suggested or currently being used to address these concerns:

If referrer is not the parent/guardian then complete the following

REFERRER INFORMATION

Referrer Name:	Referrer Role: (e.g. class teacher, network coordinator)
Referrer Phone contact: Suitable contact time:	Referrer Address:
Has consent for this referral been obtained from client, parent or guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	