WBSAS
Wide Bay Sexual Assault Services

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e: admin@trauma-assist.com.au w: www.wbsass.com.au

Date: ___/___/_____

Referral Form

Email Referral to referrals@trauma-assist.com.au

Client`s name: _____ DOB: ___/___/_____ Gender: M ☐ F ☐

Address: _____ Occupation: _____ ATSI: _____

Contact Person: _____ Relationship to Client: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Referred by: _____ Agency: _____

Position: _____ Work Phone: _____ Email: _____

Purpose of Referral: _____
_____
_____
_____
_____

Please tick the boxes if the client presents with current or historical:

☐ Mental Health Concerns/Diagnosis ☐ Substance Abuse ☐ Criminal Record
☐ Suicidal Ideation ☐ Exposure to Domestic Violence ☐ Risk Taking Behaviour
☐ Problematic Sexualised Behaviours ☐ Self-Harm ☐ Medical Issue

Please Specify if Any: _____
_____
_____
_____

Client`s Goals: _____
_____
_____
_____

Preferred Counsellor Gender: ☐Female ☐ Male
Preferred Office: ☐Hervey Bay ☐Maryborough
Is it safe to leave a message/txt to the client? ☐YES ☐NO

Do you want to be informed should the client fail to attend the service? ☐Yes ☐No
Is your Service to be informed once service has ceased involvement? ☐ Yes ☐ No
Are you seeking a report regarding client progress for purpose of court proceedings? ☐Yes ☐No