Maali's Journey Referral Form

Date of Referral: __ / __ / ____

CLIENT DETAILS:

Name: ____________________________ Date of Birth: __ / __ / ____

Address: ____

Phone: ____________________________ Best time to contact: __:__ am ☐ pm ☐

Email: ____

Does the client and/or children identify as Aboriginal and/or Torres Strait Islander?
Yes ☐ No ☐

REFERRER DETAILS:

Name of person completing this form: _____________________________________

Position of person referring: ____

Organisation / Service Provider: ____

Phone: ____________________ Email: _____________________________________

Reason(s) for referral:

What kind of support would the client like from Maali's Journey? (please tick all that apply)

Counselling	☐	Domestic & Family Violence	☐
Mental Health	☐	Education	☐
Alcohol &/or Other Drug(s)	☐	Parenting	☐
Housing	☐	Social Support	☐
Cultural Support	☐		

Other (if other please provide more details below) ☐

Other than the referring organisation / service, are there are any other organisation(s) / service(s) involved with the client you are referring? Yes ☐ No ☐

If yes, please list service and what type of support the service is providing below.

Client Consent:

Has the client given consent for this referral to be made?

☐ In Person Client Signature_______________________ Date: __ / __ / ____

☐ Verbally Referrer's Signature____________________ Date: __ / __ / ____

Maali's Journey Staff Use Only

Date referral received: __ / __ / ____

Internal Referral ☐ External Referral ☐

Allocated to [Enter Staff Members Name]: _________________________________

Initial contact made: Yes ☐ No ☐ Date of contact: __ / __ / ____