NURTURE & GROW
COUNSELLING SERVICE

Ph: 0434 017 481
W:www.nurturegrowcounselling.com.au
ABN: 24247405587

Counselling Referral Form

The contents of this document are PRIVATE and CONFIDENTIAL.

Client Details			
Client Name		Date of Referral	
Gender		Date of Birth	
Address		Contact number 1	
		Contact number 2	
Email			
Preferred contact Can I leave a message	Email Phone Text Call Yes/No		

Does the client have any disabilities?	Yes	No	
Does the client require Auslan/other hearing support interpreter?	Yes	No	
Is the client a carer for a person with disabilities?	Yes	No	
Is this referral for NDIS capacity building support?	Yes	No	
Is the client COVID-19 fully - vaccinated fully	Yes	No	
Language spoken at home		Interpreter required	Yes / No

Cultural Identify		
Aboriginal	Torres Strait Islander	Aboriginal & Torres Strait Islander
Non-Indigenous with Aboriginal or Torres Strait Islander partner		Non-Indigenous with Aboriginal or Torres Strait Islander children

Parent/Guardian/Carer/Next of Kin Details			
Name		Relationship to client	
Contact Number		Email	

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Agency Involvement		
Are there any other services/agencies involved? List:	Yes	No
Is counselling a mandatory requirement?	Yes	No
Court orders in place AVO or Personal violence order?	Yes	No

Reason for Referral			
Suicide/ Self Harm	Drug &/or Alcohol &/or Gambling	Trauma: *Childhood *Vehicle *Victim of crime *Witness to offence *Involved in a traumatic incident:_____ *Other:_____	Interpersonal challenges or relationship conflict: * Family * Friends * Work colleague * Partnered relationships * Marriage breakdown * Other:_____
Family Violence	Personal-life Coaching	Grief & Loss: * Loved one * Divorce * Work * Friendship Other: _____	Mental Health: Depression Anxiety PTSD CPTSD Eating Disorder Other: _____
Job loss/ Financial	stress	General life challenges: _____	Other:_____ _____

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Name of Person Making Referral			
Agency referral	Self-referral		
Name of person making the referral		Agency	
Position		Relationship to the person being referred	
Has this person (or their legal guardian) agreed to this referral to Nurture & Grow Counselling Service?		□ Yes	□ No
Does the referral person/agency wished to be contacted before contact made to the client?		□ Yes	□ No

Address		Phone	
		Mobile	
Email			

THE REFERRED PERSON MUST SIGN THIS FORM (if over 18 years)

Signatures			
Referred Person		**Referrer (Agency)**	
Name		Name	
Signature		Signature	

Parent or Legal Guardian of a child under 18	
Name	
Signature	

Please attach any relevant supporting documents with this referral and send to Nurture & Grow Counselling Service via the options listed below:

By Email
Scan and email the completed form & any other relevant document's to: therapyservices@nurtureandgrowcounselling.com.au

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Office use only	
Date referral received Over phone/ online – website	
Date referral contact made to client	
Date contact made to the referral agency	
Allocated for action to	
Referral decision/follow up	