GUNGARDE COMMUNITY CENTRE ABORIGINAL CORPORATION
ABN: 45180964190 ICN: 148
PO BOX 6
92 CHARLOTTE STREET, COOKTOWN QLD, 4895
T: 07 40695412

REFERRAL FORM

Service cannot commence until this form has been completed in full and received by Gungarde Community Centre Aboriginal Corporation Community Centre. All information will be treated in strictest confidence. Please ensure that all relevant sections are completed and returned to Gungarde by:

In person or email: intake@gungarde.com.au

REFERRER DETAILS:

DATE:		**SOURCE OF REFERRAL:**	☐ **SELF** ☐ **FAMILY** ☐ **PROFESSIONAL**
REFERRAL NAME:		**ANGENCY NAME:**	
REFERRAL SIGNATURE:		**DATE:**	
RELATIONSHIP TO CLIENT:		**CONTACT DETAILS:**	**PHONE:** **EMAIL:**

REFERRED PERSON:

NAME:		**DATE OF BIRTH:**		**GENDER:**	
SIGNATURE:		**DATE:**			
RESIDENTAIL ADDRESS:		**POSTAL ADDRESS:**			
CONTACT NUMBER:		**EMAIL:**			
Is there anything that staff need to be aware of for their health and safety?					

REFERRED CHILD/CHILDREN:

NAME:		**DATE OF BIRTH:**		**GENDER:**	
WHERE IS CHILD/CHILDREN LIVING?	☐ Family Home ☐ Out of Home Care ☐ Other……..				
NAME:		**DATE OF BIRTH:**		**GENDER:**	
WHERE IS CHILD/CHILDREN LIVING?	☐ Family Home ☐ Out of Home Care ☐ Other……..				
NAME:		**DATE OF BIRTH:**		**GENDER:**	

WHERE IS CHILD/CHILDREN LIVING?	☐ Family Home ☐ Out of Home Care ☐ Other……..				
Is there anything that staff need to be aware of for their health and safety?					
Referred Signature:		**Date:**			

CULTURAL IDENTITY:

☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both Aboriginal and Torres Strait Islander** ☐ **Neither Aboriginal nor Torres Strait Islander**	**Country of Birth:** **First Language:** **Main Language spoken at home:** **Interpreter required:** ☐ **Yes** ☐ **No** **Torres Strait Islander**

SIGNIFICANT OTHER: E.g. Parent, Carer or significant adults.

NAME: **CONTACT NUMBER:** **RELATIONSHIP TO REFERRED:**	**NAME:** **CONTACT NUMBER:** **RELATIONSHIP TO REFERRED:**
NAME: **CONTACT NUMBER:** **RELATIONSHIP TO REFERRED:**	**NAME:** **CONTACT NUMBER:** **RELATIONSHIP TO REFERRED:**

INVOLVEMENT FROM OTHER SERVICES:

PROGRAMS/SERVICES AVAILABLE: (PLEASE CIRCLE ALL APPLICABLE)

Emergency Relief/Personal Support **Early Childhood Coordination** **Family Wellbeing Service** **Family Participation Program** **RADIO-Remote Alcohol & Drug Interventions and Outcomes Program.**	**Gungarde Housing** **Youth Empowerment Program** **Homelessness Program** **Healing House** **Services Australia**

HIPPY-Home Interaction Program for Parents and Youngsters.	**OTHER:** _____ _____

PLEASE CONTACT OFFICE FOR MORE INFORMATION, IF NEEDED.

REASON FOR REFERRAL:

Please include all relevant information, including current presenting issues, cultural consideration, agencies currently working with the family and any risk Gungarde should be aware of:

BRIEF SUMMARY:

CONFIDENTIALLITY & CONSENT: By signing this form, I consent to participate in the program, agree to the transportation provided by Staff, acknowledge that my personal information will be collected and used in accordance with the program's confidentiality policy, and authorise the sharing of necessary details within the referred programs for my participation, safety, and well-being.

OFFICE USE ONLY:

Date Received:	**Program:**	**Accepted/Wait listed:**	**Further Action Required:**
Allocated to:	**Case No:**	**Not Accepted:**	