**A picture containing text

Description automatically generated**

**KUNJUR FIRST NATIONS MENS COLLECTIVE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENTS DETAILS** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | Age: | | | |  | | | | Date of Birth | | |  |
| Phone (Hm): |  | | | | | | | (Mb): | | | |  | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | |
| Gender: | * Male | | | * Female | | | * Other | | | Tribe, Clan, Nation: | | | | | | |  | | |
| Culture: | Aboriginal | | |  | Torres Strait Islander | | | | | |  | | CALD | | | |  | | |
| **INFORMED CONSENT** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Referring Agent | | |  | | | | | | | | | | | | | | | | |
| Service provider | | |  | | | | | | | | | | | | | | | | |
| Email Address | | |  | | | | | | | | | | | | | | | | |
| Office Number | | |  | | | | | | Mobile Number | | | | |  | | | | | |
| Client Verbal Consent provided | | | * Yes ☐No | | | | | | Signed by referring agency | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
| **DOMAIN OF CONCERN** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| * Housing | | | | | | * Education or Employment | | | | | | | | | * Family & Relationships | | | | |
| * Social Connections | | | | | | * Physical Health | | | | | | | | | * Mental Health | | | | |
| * Drugs & Alcohol | | | | | | * Safety and Law | | | | | | | | | * Cultural Connections | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Please provide details/ reason for referral/ expected outcome from engagement. Where possible, please provide any care plans created and mandatory requirements the participant must meet. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **OFFICE ONLY** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Referral received | |  | | | | | | | Date reviewed | | | | | | | | |  | |
| Lead | |  | | | | | | | Approved/Denied | | | | | | | | |  | |
| Referral Closed | |  | | | | | | | Referred to if Denied | | | | | | | | |  | |