

1. Referrer Details

| | | | |
|---|---------|--|--------|
| Referrer Name | | | |
| Referrer Organisation | | | |
| Contact details | Work Ph | | Mobile |
| Email address | | | |
| Relationship to Client Position/Role | | | |

2. Client Details

| | | | | | | |
|---|--|-------------------------------|---|---|---------|--|
| Client Name | | D.O.B | / | / | Pronoun | |
| Preferred Name | | | | | | |
| Contact details | Home | | Mobile | | | |
| Email address | | | | | | |
| Preferred option for communication | <input type="checkbox"/> Email <input type="checkbox"/> Phone | <input type="checkbox"/> Post | Do they identify as Aboriginal and Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Residential Address: | | | | | | |
| Postal Address (If different from above) | | | | | | |

For client under the age of 18, under guardianship or in the care of family or caregivers, please complete below

| | | | | |
|---|---------------------------------|-----------------------------------|------------------------------------|--------------------------------|
| Name of Parent/Guardian 1 | Primary Carer | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Lives with Client | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Emergency Contact | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Relationship to client | <input type="checkbox"/> Parent | <input type="checkbox"/> Guardian | <input type="checkbox"/> Caregiver | <input type="checkbox"/> Other |
| Residential Address: | | | | |
| Postal Address (if different from above) | | | | |
| Contact details | Home | | Mobile | |
| Email address | | | | |

| | | | | |
|----------------------------------|---------------------------------|-----------------------------------|------------------------------------|--------------------------------|
| Name of Parent/Guardian 2 | Primary Carer | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Lives with client | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Emergency Contact | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Relationship to client | <input type="checkbox"/> Parent | <input type="checkbox"/> Guardian | <input type="checkbox"/> Caregiver | <input type="checkbox"/> Other |
| Residential Address: | | | | |
| Postal Address | | | | |

| | | | |
|---------------------------|------|--|--------|
| (if different from above) | | | |
| Contact details | Home | | Mobile |
| Email address | | | |

3. Please provide information about conditions that may impact their outdoor session. Disability / Medical Conditions including any diagnosis if relevant.

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| 1. |
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| 2. |
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| 3. |
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4. Preferences

| | |
|------------------------|--|
| Religious Requirements | |
| Cultural Requirements | |
| Other Considerations | |

Sa Reay Counselling specialise in Outdoor Therapy, please mark any/all that apply.

- They find it too confronting to sit across from someone in an office setting
- They love the idea of movement and being outside during a session
- They have tried office-based therapy and it just wasn't for me
- They can't keep still and don't like to remain seated for long
- They get anxious / nervous /overwhelmed in an office
- They want to deal with a fear in the outdoors such as fear of crowds, social anxiety, spiders etc.
- They need support to go for a walk and/or to be around others
- Other

Please describe your reason for this referral.

Please answer the following questions to the best of your knowledge



| | YES | NO | UNSURE | RATHER NOT SAY |
|---|-----|----|--------|----------------|
| Have they previously seen a counsellor, psychologist, or therapist? | | | | |
| Are they involved in any court proceedings, or do you require a legal report? | | | | |
| Do they use drugs or do they drink alcohol to excess? | | | | |
| Have they ever experienced any form of domestic violence? | | | | |
| Have they been convicted of any crimes involving violence? | | | | |
| Is there any previous mental health hospitalisation or issues that we should be aware of? | | | | |

If you answered "Yes" to any of the above questions, can you add any additional information here?

Are there any considerations Sa Reay Counselling need to know in relation to your culture, gender, living arrangements or privacy, linguistic diversity, disabilities or accessibility. Any information Sa Reay Counselling need to know to ensure the service provided is tailored to their needs? If you answer "Yes" to this question, please add information below.

Is the client aware of this referral?

Can Sa Reay Counselling contact the client directly?

I understand that:

- This organisation owns these records.
- Clients can ask to see records and receive a copy
- Records are archived for a set period according to policy and procedure
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Referrer Signature:

Date: _____