

**USC COMMUNITY COUNSELLING CLINIC: REFERRAL FORM-AGENCY**

Client Details			
<b>Client Name</b>		<b>Date of Birth</b>	
<b>Gender</b>	M F NB	<b>Car Rego</b>	
<b>Address</b>		<b>Contact Ph</b>	<b>Hm:</b> <b>M:</b> <b>Preferred Contact Ph TxT E</b>
<b>Email</b>			
<b>Next of Kin / Parent / Guardian/ Carer</b>			
<b>Name</b>		<b>Relationship to Client:</b>	
<b>Contact Number</b>		<b>Email</b>	
<b>Does the client have any disability</b>		<b>Yes</b>	<b>No</b>
<b>Please specify</b>			
<b>Cultural Identity</b>			

Reason for Referral	
Mental Health Challenges: Has the client identified or is there evidence of the following please indicate and or comment if appropriate.	
Suicidality	
Self Harm	
Aggression or hostiles behaviours	
History or current Mental Illness	
Distress or Agitation	
Legal or Court Related issues	

<b>Referrer's Details</b>	<b>Date of Referral</b> /    /
<b>Agency referral</b>	
<b>Referring Agency:</b>	
<b>Address:</b>	
<b>Contact Details: Ph:</b>	
<b>Email:</b>	
<b>Referrers Name:</b>	<b>Signature:</b>

<b>Lodgement of Referral</b>
<p>All referrals need to emailed to:</p> <p><a href="mailto:Counsellingclinic@usc.edu.au">Counsellingclinic@usc.edu.au</a></p> <p>Building J, Ground Floor          USC Sippy Downs Campus          90 Sippy Downs Drive QLD 4556          Phone: 07 54565006</p>