**North Australian Aboriginal Family Legal Service- Counselling**

**Agency Referral**

For NAAFLS NT, contact [admin@naafls.com.au](mailto:admin@naafls.com.au) or Ph: 1800 041 998

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| --- | --- | --- | --- | --- |
| **CLIENT INFORMATION** | | | | |
| Name of Client: DOB:  Address:  Email: Gender: Male / Female  Phone Number: Cultural Background: |  | |  |
| **REFERRING AGENCY** |  | | | |
| **Referring Agency** : |  | **Phone:** | | |
| **Contact Name:**  **Reason for Referral:**  **Other Services involved with the Client:**  **Risk alerts to self or others (Including Alcohol/Drug Use, Mental Health Diagnosis, Self Harm and Suicide Ideation,**  **Domestic Violence):** | **Email:** |  | | |
| **PROCESS OF REFFERAL** | | | | |
| Client will contact NAAFLS-HS directly and have been given contact details  Client has given permission for NAFFLS-HS to contact them directly  Client agrees to be contacted via email if phone contact is not available  Client agrees to have reminder SMS sent to their nominated mobile phone and/or email (circle one) prior to their appointments | | | | |
| **CONSENT** | | | | |
| Written Consent given  Verbal Consent given  I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understood the above information. I agree to this information being provided to NAAFLS Counselling.  **Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Worker Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  | | | | |  | **NOTE**: If a conflict is identified please contact PLO  **Date**: |