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

**Agency Referral**

For NAAFLS NT, contact 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**:                       |