

Counselling & Psychology Client Details Form

Please fill out this form and return it to Independence Australia at

psychology@independenceaustralia.com

208 Wellington St, Collingwood, 3066: Ph 1300 704 456, Fax: 1300 704 451

Date Referral Completed: ____/____/____

PROSPECTIVE CLIENT DETAILS

Name:	_____	Client's Date of Birth:	_____
Address:	_____		
Post Code:	_____		
Contact Details:	Ph (priv) _____	Ph (wk) _____	Mob _____
Client (or family member's) disability (diagnosis, duration, severity, etc)	_____		

REFERRER DETAILS

Name of referrer (your name):	_____		
Name of Agency you are affiliated with:	_____		
What is your relationship to the client?	_____		
Your Contact Details :	Ph (priv) _____	Ph (wk) _____	Mob _____

REASONS FOR REFERRAL

Briefly describe the main issues / concerns that led to this referral

How long have these issues / concerns been a problem? _____
• Is the client aware that you are making this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Please note, clients will only be contacted if they are aware of, and in agreement with the referral being made.

URGENCY OF REFERRAL

Please rate how urgent this referral is, and give reasons: Very Urgent Moderately Urgent Can Wait

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CLIENT BACKGROUND INFORMATION

To assist with establishing client needs / tailoring our service, please tick the relevant boxes.

Client's Current Mood	Frustrated / agitated <input type="checkbox"/> Sad / depressed / tearful <input type="checkbox"/>	Angry / aggressive <input type="checkbox"/> Stressed / tense /worried <input type="checkbox"/>	Lonely / isolated <input type="checkbox"/> Irritable / Moody <input type="checkbox"/>
Current Supports From Family / Friends	Few supports available <input type="checkbox"/>	Moderate support <input type="checkbox"/>	Strong supports <input type="checkbox"/>
Client's Hope For Change	Hopeful <input type="checkbox"/>	Uncertain <input type="checkbox"/>	Hopeless <input type="checkbox"/>
Current Medications	Antidepressants <input type="checkbox"/>	Sleeping Pills <input type="checkbox"/>	Anti-anxiety meds <input type="checkbox"/>
Does the client experience	Body pain <input type="checkbox"/>	Trouble sleeping <input type="checkbox"/>	Problems with Fatigue <input type="checkbox"/>
Current medical illness (in addition to disability)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
Current problematic alcohol / drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
Current or past thoughts of suicide?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
Suicide attempt/s?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
History of aggression / violence towards others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
Current or past problems with domestic violence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
Current or past trouble with the law?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
If Yes to any of the above, please elaborate:			

HEALTH PROFESSIONALS INVOLVED

Please indicate which professionals are *currently* involved in this person's emotional or physical health care (Note : we will *not* contact any people listed without obtaining the client's permission first).

	Tick	Name of Professional	Practice Name/ Location and Contact number
General Practitioner	<input type="checkbox"/>		
Medical Specialist _____	<input type="checkbox"/>		
Counsellor / Psychologist	<input type="checkbox"/>		
Psychiatrist	<input type="checkbox"/>		
Case Manager / Social Worker	<input type="checkbox"/>		
Physiotherapist	<input type="checkbox"/>		
Occupational Therapist	<input type="checkbox"/>		
Other _____	<input type="checkbox"/>		

FUNDING

What funding does the client receive? : None Medicare* TAC Workcover , Pension , DHS Funded Package _____ Other _____ *Client may need a Mental Health Plan from GP (Item NO. 2710)