

FREEDOM COUNSELLING REFERRAL FORM

Eligibility criteria for counselling: Aged 12 -25 years old, identify as LGBTIQ+

The Freedom counselling service is **NOT** a crisis service. If there is risk present WAAC will have to work in collaboration with a lead agency

Please complete referral form and send to freedomcounselling@waac.com.au or call (08) 9482 0000 for any queries

Referral date:
Is the young person aware of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Referral source:

YOUNG PERSON'S DETAILS:			
Chosen name:		Pronouns:	
Date of birth:			
Address:			
Phone:		Email:	
Legal name: (if different to above)		LGBTIQA+:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Preferred Mode of Contact: Call <input type="checkbox"/> SMS/Text <input type="checkbox"/> Email <input type="checkbox"/>			
If we leave a message, can we say we are from WAAC/Freedom? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Location for counselling:	In Person - Leederville (Freedom Centre) <input type="checkbox"/> In Person - West Perth (WAAC) <input type="checkbox"/> Telehealth <input type="checkbox"/>		
Does the young person have access to IT and internet for telehealth counselling? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Any considerations for young person? e.g. accessibility, cultural, interpreting needs, sensory, information processing etc.			

Does the young person identify as Aboriginal or Torres Strait Islander?	Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Non-Indigenous <input type="checkbox"/>
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EMERGENCY CONTACT:			
Name:		Pronouns:	
Relationship:			
Address:			
Phone:		Email:	
What name and pronouns does the emergency contact use for the young person:			

REASON FOR REFERRAL								
Please provide reason for referral:								
<p>Current Risk/Safety Issues:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Suicide</td> <td><input type="checkbox"/> Justice/Legal issues</td> </tr> <tr> <td><input type="checkbox"/> Self-Harm</td> <td><input type="checkbox"/> Drug/Alcohol</td> </tr> <tr> <td><input type="checkbox"/> Harm to others</td> <td><input type="checkbox"/> Home life</td> </tr> <tr> <td><input type="checkbox"/> Harm from others</td> <td><input type="checkbox"/> Other</td> </tr> </table> <p>Please give detail (inc. risk level, timeline):</p> <p>Please attach any additional documentation (e.g. safety plan, risk assessments)</p>	<input type="checkbox"/> Suicide	<input type="checkbox"/> Justice/Legal issues	<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Drug/Alcohol	<input type="checkbox"/> Harm to others	<input type="checkbox"/> Home life	<input type="checkbox"/> Harm from others	<input type="checkbox"/> Other
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<input type="checkbox"/> Harm from others	<input type="checkbox"/> Other							
Does the young person have any diagnoses, ongoing illnesses or conditions? (e.g., physical, mental or psychosocial conditions)								
Is the young person taking any medication? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list below:								
Has the young person been admitting to hospital in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list relevant admissions below:								

<p>If relevant, is the young person wanting to access gender affirming care? (legal, medical, social) Currently on waitlist <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Additional information: (family, living and social situation, education, employment, medications)</p>

OTHER SERVICES DETAILS:			
Contact person:		Pronouns:	
Organisation:		Position:	
Phone:		Email:	
Contact person:		Pronouns:	
Organisation:		Position:	
Phone:		Email:	
Contact person:		Pronouns:	
Organisation:		Position:	
Phone:		Email:	

REFERRER'S DETAILS:			
Name:		Pronouns:	
Organisation:		Position:	
Phone:		Email:	
Contact referrer prior to contacting young person? Yes <input type="checkbox"/> No <input type="checkbox"/>	Has young person attended WAAC before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>		