



Name of person
submitting referral:

Organisation /
Position:

Contact details:

Client name:

DOB

Email:

Mobile
phone:

Home
phone:

Reason for referral: i.e. counselling, safe sex products, peer workshops etc.

Additional comments: is there additional information that may assist us in following up this referral, or that we should be made aware of in supporting the client?

The information collected in this form is intended to enable staff of Westlund Counselling and AIDS Action Council Client Services to fully meet the needs of our clients. If you have any questions in relation to this form, please contact our team on 02 6257 2855.

Please email your form to counselling@aidSACTION.org.au once completed.

Please have the client sign this referral so that they are aware of the reason of the referral and consent to this information being shared. By signing this consent the client also agrees that we can contact the referring agency to discuss information contained in the referral.

Client Consent

I _____ give consent for Westlund Counselling and AIDS Action Council to contact the service / person listed above for the purpose of gathering information in relation to my referral.

Signature: _____ Date: _____

Confidentiality and Privacy

Client Records are stored on a computerised database, with multiple password protection and accessible only to authorised AIDS Action Council staff involved in Clients services. Clients should be aware that all staff of the AIDS Action Council are also required to sign and adhere to a Confidentiality Agreement.

Referring person's declaration:

The information contained in this referral has been completed to the best of my knowledge. The reason for the referral has been explained to the client and I am unaware of any further information that could impact the outcome of the referral.

Signature: _____ Date: _____

Office Use

Referral received: _____ / _____ / _____ by staff member: _____

Referral outcome and reason:

Referring organisation contacted: _____ / _____ / _____ by staff member: _____

Intake appointment scheduled for: _____ / _____ / _____ time: _____ : _____ am / pm