Community Referral Form

Mount Gambier
HEAD TO
HEALTH

*Referrer to complete form and fax to **(08) 8582 5050** or email to*
referrals@focusonehealth.com.au

Referrers Details		
Date of Referral:	Referrers Name:	
Referring Organisation:	Phone Number:	
Email:		
Does the client consent to referral? FocusOne Health is a voluntary service and all clients must consent to and be willing to engage in services		☐ Yes ☐ No

Client Details		
Name:		DOB:
Gender:	Sex:	Age:
Address:		
Home Phone:	Mobile:	
Email:		
General Practice:		

Client information				
In case of Emergency contact	Name:		Phone:	
Does the client identify as:	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Neither
Country of Birth:				
Does the client speak a language other than English?	☐ No	☐ Yes (please state)		
Ability to speak English	☐ Very Well	☐ Well	☐ Not Well	☐ Not At All
Do you live alone:	☐ Yes	☐ No (with whom)		
Accommodation:	Stable ☐	Unstable ☐	No fixed address ☐	
Marital Status:	☐ Single	☐ Married	☐ Defacto	☐ Other:
Occupation Status:	☐ Unemployed	☐ Employed Full-time ☐ Employed Part-time	☐ Casual	☐ Studying F/T ☐ Studying P/T
Occupation:				
Education Level:				

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Current help seeking	
Is the client currently engaging with or being supported by any other services?	☐ Yes ☐ No
If Yes, please detail who /how:	
What are the main issues of concern at the moment?	