



IF THE SAFETY OF CLIENT YOU ARE REFERRING IS AT RISK OR THEY ARE IN CRISIS PLEASE **DO NOT** REFER THE CLIENT USING THIS FORM. PLEASE CALL OUR SAFETY TEAM ON 3816 3000 TO SPEAK WITH A SAFETY TEAM PRACTITIONER.

EXTERNAL AGENCY REFERRAL

Date:

Referring agency:

Contact person:

Warm referral preferred:

Phone:

Email:

CLIENT DETAILS

Name:

DOB:

Contact numbers: Home

Mobile

Permission to leave message: Yes No

Text message preferred: Yes

Legal guardian (if applicable):

Address:

School/education facility (if applicable):

Identifies as: Indigenous Aboriginal Torres Strait Islander Both Neither CALD

Primary language spoken at home: Interpreter required: Yes No

Disability (physical/mental/intellectual): Yes No Type:

REASON FOR REFERRAL (why is the client seeking support now; recent trigger/s; therapeutic goals):

SEXUAL VIOLENCE INFORMATION

Historical sexual assault Childhood sexual assault Recent disclosure

ACUTE (LESS THAN 24 HRS TO 1 MONTH): CONTACT SEXUAL ASSAULT RESPONSE TEAM 24 HR LINE (3202 2766)

Alleged offenders name: Ongoing risk of harm: Yes No Unknown

Reported: Police: Yes No N/A Support required to report: Child Safety: Yes No N/A

Youth Justice Conference (if applicable): Court:

Family Law Court involvement: Yes No N/A

Victim Assist Queensland (VAQ) application submitted: Yes No Unknown

