

Please email to admin@engenderequality.org.au or phone 03 6278 9090 for more information

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|----------------|--|
| Referral date: | |
|----------------|--|

Referrer Details:

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|---------------|--|
| Name: | |
| Organisation: | |
| Phone: | |
| Email: | |

Client Details:

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|----------|--|------------------------|--|
| Name: | | DOB: | |
| Gender: | | Preferred pronouns: | |
| Phone: | | Is phone safe to call? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | Is phone safe to text? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Address: | | | |

Childrens Details:

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|--------------------|--|------|--|
| Child's full name: | | DOB: | |
| Child's full name: | | DOB: | |
| Child's full name: | | DOB: | |
| Child's full name: | | DOB: | |
| Child's full name: | | DOB: | |

Family Violence Orders:

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|--------------------------------------|--|----------|--|
| Police Family Violence Order (PFVO): | YES <input type="checkbox"/> NO <input type="checkbox"/> | Expires: | |
| Family Violence Order (PFVO): | YES <input type="checkbox"/> NO <input type="checkbox"/> | Expires: | |
| Conditions: | | | |

Additional Information:

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|--|--|---|-----------------------------|
| Aboriginal or Torres Strait Islander: | Aboriginal <input type="checkbox"/> | Torres Strait Islander <input type="checkbox"/> | No <input type="checkbox"/> |
| Culturally and linguistically diverse: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Country of Birth: | |
| Recent separation: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Difficulty using stairs: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Drug and alcohol use: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Mental health diagnosis: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |

Reason for Referral/Assessment:

Client Assessment of Own Risk:

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|---|--|----------|--|
| Fears for safety: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Fears for children's safety: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Fears for others: (eg family, pets, friends) | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |
| Pregnant or recent birth: | YES <input type="checkbox"/> NO <input type="checkbox"/> | Details: | |

Service Required:

| | |
|--|---|
| Region: | Hobart <input type="checkbox"/> Launceston <input type="checkbox"/> North West <input type="checkbox"/> |
| *Is client aware of the referral? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <input type="checkbox"/> Face to face counselling <input type="checkbox"/> Zoom/phone counselling for regional clients or those with access challenges <input type="checkbox"/> Support groups | |

*Engender only takes referrals made in conjunction and with informed consent of the client