Engender Equality

REFERRAL FORM

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

Referral date:	

Referrer Details:

Name:	
Organisation:	
Phone:	
Email:	

Client Details:

Name:			DOB:	
Gender:		Preferred pronouns:		
Phone:		Is phone safe to call? Is phone safe to text?	YES ☐ NO ☐ YES ☐ NO ☐	
Address:				

Childrens Details:

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:

Police Family Violence Order (PFVO):	YES ☐ NO ☐	Expires:	
Family Violence Order (PFVO):	YES ☐ NO ☐	Expires:	
Conditions:			

Engender Equality

REFERRAL FORM

Additional Information:

Aboriginal or Torres Strait Islander:	Aboriginal ☐ Torres Strait Islander ☐ No ☐		
Culturally and linguistically diverse:	YES ☐ NO ☐	Country of Birth:	
Recent separation:	YES ☐ NO ☐	Details:	
Difficulty using stairs:	YES ☐ NO ☐	Details:	
Mental health diagnosis:	YES ☐ NO ☐	Details:	

Reason for Referral/Assessment: (Also note here anything else the client would like us to know - e.g. substance abuse)

Client Assessment of Own Risk:

Fears for safety:	YES ☐ NO ☐	Details:	
Fears for children's safety:	YES ☐ NO ☐	Details:	
Fears for others: (eg family, pets, friends)	YES ☐ NO ☐	Details:	
Pregnant or recent birth:	YES ☐ NO ☐	Details:	

Service Required:

Region:	Hobart ☐ Launceston ☐ North West ☐
*Is client aware of the referral?	YES ☐ NO ☐

☐ Face to face counselling

☐ Zoom/phone counselling for regional clients or those with access challenges

☐ Support groups

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