# **REFERRAL FORM**

Please send completed form and relevant information to [supportingrecovery@lchs.com.au](mailto:supportingrecovery@lchs.com.au)

Gippsland Supporting Recovery Program provides a range of therapies for children, young people, adults and/or families who want support to heal from experiences of family, domestic, and/or sexual violence. Our service extends to those from Latrobe City or Baw Baw Shires and feel emotionally ready for the healing process.

**Gippsland Supporting Recovery Program is not an emergency service and are not able to respond to immediate crisis needs. If deemed ineligible, we will discuss available options.**

Date: Click or tap to enter a date.

**Consent**

*Note: where the person being referred for service is a child or young person, consent must be obtained from a parent or legal guardian unless deemed to be a mature minor.*

The referred person agrees to this referral

The referred person is a mature minor

The referred person is part of a family group requiring support

**Eligibility**

Has current or past family, domestic and/or sexual violence been identified? Yes  No

Are there any current risks that we need to be aware of? Yes  No  Unknown

Additional details:

**Supporting Information**

MARAM Risk Assessment  Safety Plan

Other supporting attachments?  E.g. IVO, mental health/other assessments Click or tap here to enter text.

***A separate Referral Form is required for each person referred***

**Referrer**

Is this a self-referral? Referrer’s Name: Click or tap here to enter text.

No  (please complete this section🡺) Phone: Click or tap here to enter text.

Yes  (please move to next section🡻) Email Address: Click or tap here to enter text.

Position / Organisation: Click or tap here to enter text.

**Person seeking a service**

First Name: Click or tap here to enter text. Surname: Click or tap here to enter text.

Preferred Name: Click or tap here to enter text. Other names used: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text. Contact Information: Click or tap here to enter text.

Current Residential Address: Click or tap here to enter text.

How do you prefer to communicate with us? Phone  SMS

Email  Other: Click or tap here to enter text.

Gender identity: Click or tap here to enter text. Pronouns: Click or tap here to enter text.

Country of birth: Click or tap here to enter text.

Cultural background: Click or tap here to enter text. Interpreter required: Yes  No

Identify as Aboriginal or Torres Strait Islander? Yes  No

**Presenting Needs**

What are the areas of concern?

Anxiety  Feeling depressed  Feeling isolated/alone  Feelings of shame or worthlessness

Grief and loss  Mood swings  Parenting challenges  Self-doubt  Sexual trauma

Stress  Post-Traumatic Stress Disorder symptoms  Self Harm/thoughts of suicide  Other

Additional details:

Briefly describe supports required to promote wellness:

Please provide any current mental health diagnoses or conditions.

**Emergency Contact**

Who can we contact if we are not able to reach you?

Name: Click or tap here to enter text. Contact Number: Click or tap here to enter text.

Relationship to you: Click or tap here to enter text.