**Service Provider Referral Form**

**Date:**

| **CLIENT DETAILS** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **First Name:** | | | | **Surname:** | | |
| **Gender:** | **Date of Birth**: | | | | | **Place of Birth:** |
| **Mobile:** | **Address:** | | | | | **Post Code:** |
| **Aboriginal or Torres Strait Islander:** | | | | **Main Language Spoken at Home:** | | |
| **Interpreter required?** | | | | **Consent to refer service confirmed with the client?** | | |
|  | | | | | | |
| **Presenting issues(s) as identified by client or representative:** | | | | | | |
| **Reason for referral as identified by service provider:** | | | | | | |
| **Presenting and underlying issues:**  **Significant history:** *(medical, medication issues, developmental, functional/daily living skills, social, emotional, trauma – including abuse of neglect, etc.)*Unknown.  **Social, spiritual and diversity considerations:** | | | | | | |
| **Current services:** *services used in the last 12 months* | | | | | | |
|  | | | | | | |
| **Referred service provider:** | | | **Service Contact:** | | | **Follow-up arrangements:** |
| **This information collected by:** | | | | | | |
| **Name:** Jacob Gilmour  **Contact:** 0478 315 813  jgilmour@warrnambool.vic.gov.au | | **Position/Agency:** Community Connections Officer, Warrnambool City Council | | | **Date:**  **Sign:** | |

**Consent to Share Information**

**We are committed to protecting the confidentiality of your personal information, however there may be times where we need to share your information to gain more support to suit your current needs and to better improve our services that we provide to you.**

**The Warrnambool City Council** may share your information with providers of Services such as an assessment worker, an aged care provider, a residential care facility which is managing your care, a hospital or a health professional.

We may also share your information with your family member, friend or other person who is providing you with care (if they are authorised to receive your personal information).

**If you do not consent for your information to be shared in the above manner your services will still continue and referrals for services can still proceed.**

**Client Consent**

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| My worker has discussed with me how and why certain information about me may need to be provided to other service providers.  I understand and give permission for the information to be shared as detailed above.  Signed: Date:    Signed by:  Client OR  Authorised Representative OR  Verbal Consumer Consent  Name:  Date:  Witnessed: |