Family Wellbeing
Community Referral Form

Please note this community referral is a provisional referral and it will only provide access to an intake appointment. A **Child Treatment Plan** needs to be completed by a GP to gain full access to the service.

Date of referral:	

Client details

Name:			
DOB:		Gender:	
Address:		Home number:	
		Mobile number:	
Parent/Caregiver:		Relationship to client:	

Referrer details

Name:			
Phone:		Fax:	
Organisation:		Address:	

Reasons for referral:

Is the child a member of any of the following Priority groups? (please tick below)
☐ Aboriginal or Torres Strait Islander
☐ CALD or Migrant background
☐ Suspended/excluded from school
☐ Involved with the Juvenile Justice System
☐ Known/involved with DCP or at risk of DCP involvement

Any other agency involvement?	☐ Yes (please provide details below)	☐ No	☐ Unsure

Does the client have a GP?		☐ Yes ☐ No	
Name:		Phone:	
Organisation:		Address:	

Consent

I, _____, agree to be referred to Sonder.

Client signature: _____ **Date:** _____

Referrer signature: _____ **Date:** _____

Client consent to release information (if applicable)

I, _____ (Client's full name) give my permission for

_____ (Referrer's full name) to provide/receive

written and verbal information to/from Sonder for the purpose of facilitating this referral.

Client signature: _____ **Date:** _____

Referrer signature: _____ **Date:** _____

For clients under 16 years:
Parent/guardian name:_____ **Parent/guardian signature:** _____

Please fax completed referral form to the Central Referral Unit on 1300 580 249.