

School Counselling Program Initial Referral Form

Referral date DD MM YYYYY	Name of person making the referral	Relationship to the student		
Counsellor	Class teacher and room nu	umber (IF APPLICABLE)		
Student Details				
Name FIRST Address ADDRESS	LAST			
SUBURB	STATE	POSTCODE		
Date of birth DD	Year level / Age	Is the student aware of the referral? ☐ Yes ☐ No		
Country of birth Strait Islander origin? No Intellectual Learning Physical/Diverse Yes, Aboriginal Yes, Aboriginal Yes, Aboriginal Yes, Torres Strait Islander Yes, Torres Strait Islander Interpreter required? Yes No Are there Family Court Orders or Intervention Orders in place for the family? Acopy of the orders must be presented for counselling to commence. Aboriginal No Intellectual Learning Physical/Diverse Psychiatric Sensory/Speech Other/ Do not wish to say No Are there Family Court Orders or Intervention Orders in place for the family? Yes A copy of the orders must be presented for counselling to commence.				
Name FIRST	LAST	Date of birth DD MM YYYY		
Phone number	Email address			
Address Address				
SUBURB	STATE	POSTCODE		
Country of birth Language spoken at home Interpreter required? Yes No	Aboriginal or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander I prefer not to disclose Does the parent, live with a disab No No Physical/Diverse Psychiatric Sensory/Speech Other/ Do not wi	aware of the referral? ☐ Yes ☐ No ning		



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Parent/ Caregiver Details			
Name		Date of b	irth
FIRST	LAST	DD	MM
Phone number	Email address		
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Address			
ADDRESS			
SUBURB	STATE	POSTO	CODE
Country of hinth	Aborioinal or Torres	Doos the percent /coresiver	Is the perset/superline
Country of birth	Aboriginal or Torres Strait Islander origin?	Does the parent/caregiver live with a disability?	Is the parent/guardian aware of the referral?
	□No	No	Yes No
Language spoken at home	Yes, Aboriginal	Intellectual Learning	
	Yes, Torres Strait Islander I prefer not to disclose	Physical/Diverse	
Interpreter required? Yes No		Psychiatric Sensory/Speech	
		Other/ Do not wish to say	
Reasons for referral			
Suggested counselling goals/	outcomes		