Centacare
Catholic Family Services

School Counselling Program
Initial Referral Form

Referral date
DD | MM | YYYY

Name of person making the referral

Relationship to the student

Counsellor

Class teacher and room number (IF APPLICABLE)

Student Details

Name
FIRST | LAST

Address
ADDRESS
SUBURB | STATE | POSTCODE

Date of birth
DD | MM | YYYY

Year level / Age

Is the student aware of the referral?
☐ Yes ☐ No

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 student live with a disability?
- ☐ No
- ☐ Intellectual Learning
- ☐ Physical/Diverse
- ☐ Psychiatric
- ☐ Sensory/Speech
- ☐ Other/ Do not wish to say

Are there Family Court Orders or Intervention Orders in place for the family? ☐ Yes ☐ No
A copy of the orders must be presented for counselling to commence.

Parent/ Caregiver Details

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
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- ☐ I prefer not to disclose

Does the parent/caregiver live with a disability?
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- ☐ Other/ Do not wish to say

Is the parent/guardian aware of the referral?
☐ Yes ☐ No

Please turn the page over

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FIRST

LAST

Date of birth

DD MM YYYY

Phone number

Email address

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Is the parent/guardian aware of the referral?

☐ Yes ☐ No

Reasons for referral

Suggested counselling goals/outcomes