|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Please complete all relevant sections of the form and ensure all information is accurate.*  **Email Completed form to** [**Intake@gallangplace.org.au**](mailto:Intake@gallangplace.org.au)  *ALL information on this form is treated as confidential as per Gallang Place’s Policies and Procedures* | | | | | | | |
|  |
| OFFICE USE ONLY: | | | | | | | |
| Intake Officer |  | | | Date received | | |  |
| ProGRAM allocated | Fee For Service  Employmee Assistance  ADult  Youth  Other | | | MMEX ID | | |  |
|  | | | | | | | |
| ***Client Details*** | | | | REFERRAL DATE | | |  |
| Name |  | | | DATE OF BIRTH | | |  |
| Home Address |  | | | Client Email Adress | | |  |
| PHONE |  | | | Have you used gallang services before? | | | Y N |
| GENDER | MALE FEMALE OTHER | | | | | | |
| Which do you identify as? | | TORRES STRAIT  ISLANDER | BOTH | | | ABORIGINAL | |
| next of kin | |  | Emergency Contact | | |  | |
|  | | | | | | | |
| Do you have a clinical Diagnosis  (eg anxiety, depression) | | Y N  *If Yes, please specify in notes section* | Do you Currently access Other services | | Y N | | |
| **Type of Support: *Only if comfortable providing*** | | | | | | | |
| Abuse - Sexual  Abuse - Physical  Anger Management  Behavioural  Domestic Violence | | Drug / Alcohol  Grief and Loss  Housing  Neglect  Parenting | Relationship  Suicide / Self Harm  Self-esteem  Sexuality  Trauma | | | Anxiety  Depression  Stress  Workplace issues  Homelessness  Other, *please specify in*  *notes section* | |
| ***Notes***  *I have attached additional information* | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| ***Referrer Details IF self Referral –*** *please identify other service providers* | | | | | | | |
| REFERRER Name | |  | Relationship | | |  | |
| REFERRER email | |  | | | | | |
| REFERRER Contact No. | |  | AGENCY [IF APPLICABLE] | | |  | |