



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	<input type="checkbox"/> FEE FOR SERVICE <input type="checkbox"/> EMPLOYMEE ASSISTANCE <input type="checkbox"/> ADULT <input type="checkbox"/> YOUTH <input type="checkbox"/> OTHER	MMEX ID	

### CLIENT DETAILS

REFERRAL DATE		
NAME		DATE OF BIRTH
HOME ADDRESS		CLIENT EMAIL ADDRESS
PHONE		HAVE YOU USED GALLANG SERVICES BEFORE? <input type="checkbox"/> Y <input type="checkbox"/> N
GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	
WHICH DO YOU IDENTIFY AS?	<input type="checkbox"/> TORRES STRAIT ISLANDER <input type="checkbox"/> BOTH	<input type="checkbox"/> ABORIGINAL
NEXT OF KIN		Emergency Contact

DO YOU HAVE A CLINICAL DIAGNOSIS (eg anxiety, depression)	<input type="checkbox"/> Y <input type="checkbox"/> N <i>If Yes, please specify in notes section</i>	DO YOU CURRENTLY ACCESS OTHER SERVICES	<input type="checkbox"/> Y <input type="checkbox"/> N
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### TYPE OF SUPPORT: ONLY IF COMFORTABLE PROVIDING

<input type="checkbox"/> Abuse - Sexual <input type="checkbox"/> Abuse - Physical <input type="checkbox"/> Anger Management <input type="checkbox"/> Behavioural <input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Drug / Alcohol <input type="checkbox"/> Grief and Loss <input type="checkbox"/> Housing <input type="checkbox"/> Neglect <input type="checkbox"/> Parenting	<input type="checkbox"/> Relationship <input type="checkbox"/> Suicide / Self Harm <input type="checkbox"/> Self-esteem <input type="checkbox"/> Sexuality <input type="checkbox"/> Trauma	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Stress <input type="checkbox"/> Workplace issues <input type="checkbox"/> Homelessness <input type="checkbox"/> Other, please specify in notes section
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### 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]	