Gallang Place
Aboriginal and Torres Strait Islander Corporation

Please complete all relevant sections of the form and ensure all information is accurate.
ALL information on this form will be treated as confidential as per Gallang Place's Policies and Procedures.
Orange sections for Internal Office Use

INTAKE FORM							CLIENT ID	
PROGRAM ALLOCATED	☐ NPSM	☐ EAP	☐ DFF	☐ FFS	☐ NDIS		HEALING TEAM	
CLIENT DETAILS							REFERRAL DATE	
NAME							DATE OF BIRTH	
ADDRESS								
PHONE							TEXT MSG	☐ Y ☐ N
GENDER	☐ MALE		☐ FEMALE		☐ OTHER			
☐ ABORIGINAL	☐ TORRES STRAIT ISLANDER		☐ BOTH		☐ NON-INDIGENOUS			

REFERRAL TYPE:	☐ COUNSELLING	☐ MENTAL HEALTH SUPPORT (NPSM)	
DO YOU HAVE A CLINICAL DIAGNOSIS (eg anxiety, depression)	☐ Y ☐ N *If Yes, please specify in notes section*	DO YOU CURRENTLY ACCESS NDIS	☐ Y ☐ N ☐ in progress /applying
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 ☐ Homeless ☐ Other, *please specify in notes section*
NOTES		☐ *I HAVE ATTACHED ADDITIONAL INFORMATION*	

REFERRER DETAILS		***IF SELF REFERRAL** – PLEASE INDICATE WHO REFERRRED YOU AND ANY OTHER SERVICE PROVIDERS*	
☐ AGENCY	☐ SELF REFERRAL	☐ FAMILY/FRIEND	☐ INTERNAL GALLANG
REFERRER NAME		RELATIONSHIP	
REFERRER ADDRESS			
REFERRER CONTACT No.		AGENCY [IF APPLICABLE]	
HOW DID YOU HEAR ABOUT GALLANG	☐ WORD OF MOUTH ☐ DOCTOR/ COUNSELLOR	☐ GOOGLE ☐ PREVIOUS CLIENT	☐ PROBABTION AND PAROLE ☐ OTHER
OFFICE USE ONLY			
INTAKE OFFICER		DATE RECEIVED	