GALLANG PLACE
Aboriginal and Torres Strait Islander Corporation

INTAKE FORM

V4.5- 01.07.21

Please complete all relevant sections of the form and ensure all information is accurate.
EMAIL COMPLETED FORM TO INTAKE@GALLANGPLACE.ORG.AU
ALL information on this form is treated as confidential as per Gallang Place's Policies and Procedures

		Tracker ID	
INTAKE OFFICER		Date received	
PROGRAM ALLOCATED *SEND NDIS THROUGH PRODA*	☐ FEE FOR SERVICE ☐ EAP ☐ OTHER ☐ BSPHN ☐ LLLS ☐ PMC ☐ NPSM	HEALING TEAM	

CLIENT DETAILS		REFERRAL DATE	
NAME		DATE OF BIRTH	
ADDRESS			
PHONE		TEXT MSG OK?* LITERACY/ SAFETY	☐ 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 ☐ Homelessness ☐ Other, *please specify in notes section*

NOTES ☐ *I HAVE ATTACHED ADDITIONAL INFORMATION*

REFERRER DETAILS		***IF SELF REFERRAL –*** *PLEASE IDENTIFY OTHER SERVICE PROVIDERS*	
☐ AGENCY ☐ SELF REFERRAL ☐ FAMILY/FRIEND ☐ INTERNAL GALLANG			
REFERRER NAME		RELATIONSHIP	
REFERRER ADDRESS/ EMAIL			
REFERRER CONTACT No.		AGENCY [IF APPLICABLE]	
HOW DID YOU HEAR ABOUT GALLANG	☐ WORD OF MOUTH ☐ GOOGLE/ SEARCH ☐ PROBATION AND PAROLE ☐ DOCTOR/ COUNSELLOR ☐ PREVIOUS CLIENT ☐ OTHER		

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