Intake/Referral Checklist

Date:

Referral to Oonah How was the referral made to Oonah: ☐ Internal Referral ☐ Agency…….

☐ Phone ☐ Walk in ☐ Community Event ☐ Other ……..

I have received Oonah's Client Rights and Responsibilities statement ☐ Yes ☐ No

Personal Details

Name of person being referred**: ……** DOB: ……

Address: ……..

Phone Number: ……. Mobile: ……

Email: ……..

Parent/Guardian/Carer's Name: ……

If over 18 Emergency Contact : ……

Address: (if different from above) ……

Phone: …… Mobile: ……

Email address: ……

Preferred method of contact: ☐ Landline ☐ Mobile ☐ Email ☐Text

Can we leave a message if you are unable to answer: ☐ Yes ☐ No

Do you consent to Oonah contacting you with appointment reminders ☐ Yes ☐ No

Aboriginal or Torres Strait Islander Status:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Gender: ☐ Male ☐ Female ☐ Intersex or Transgender ☐ Non specified

Family: Number of children including ages

Name	Date of Birth	Gender

Are you: ☐ Employed ☐ Unemployed ☐ Studying ☐ Pension/benefits

Do you have a Health Care Card? ☐ Yes ☐ No Expiry Date:……CRN Number:……
Medicare number:…… Reference Number:…… Expiry Date:……
Referring Doctors Name:……
Referring Doctors Address:……
Referring Doctors Phone No:……

What is the most important thing that we can help you with today?

☐ Food ☐ Family Violence ☐ Legal Aid ☐ Fines ☐ Psychologist ☐ Counselling ☐ Osteopath

☐ Physical Health ☐ Paediatrician ☐ Optometrist ☐ Social/Emotional Wellbeing ☐ Other

What other services do you use?

☐ GP ☐ District Nurse ☐ Carer Services ☐ Eastern Health ☐ VAHS ☐ Inspiro ☐ BWAHS

☐ EACH ☐ Eastern Community Legal Centre ☐ Victorian Legal Aid ☐ NGWALA ☐ VACCA ☐ HICCI

☐ Centrelink ☐ Other…….

Are you experiencing a Chronic illness? ☐ Yes ☐ No

☐ Diabetes ☐ Heart Disease ☐ Blood Pressure ☐ Respiratory Illness ☐ Other …….

Are you registered with: ☐ NDIS ☐ My Aged Care

Do you need support to register with: ☐ NDIS ☐ My Aged Care

Are you currently attending any Oonah Programs? ☐ Yes ☐ No

Would you like information on current programs being run at Oonah? ☐ Yes ☐ No

Dental
Would you like to be referred into Dental services? ☐ Yes ☐ No

Mental Health Services

Mental Health & Support Needs: ……..
……
What are your main concerns:……..
……
……..

What Supports would you like to be referred to:

☐ AOD Outreach
☐ Social & Emotional Wellbeing (casework, housing, financial, legal, family violence, outreach support etc)
☐ Counselling (trauma, anxiety, depression, grief & loss, relationship difficulties, family violence etc.)
☐ Other

**** During the Covid-19 Pandemic if we are unable to provide a face to face option - Online or Telephone Counselling and Support can be offered.**

Do you consent to using these options where necessary ? Yes ☐ No ☐

Permission to Share Details

I give permission for Oonah to share relevant and appropriate details within the organisation as appropriate and with one or any of the following Agencies:

☐ VACCA ☐ NDIS/NDIA ☐ BWAHS ☐ EACH ☐ ANCHOR

☐ NGWALA ☐ EASTERN HEALTH ☐ EMPHN ☐ ECLC ☐ HICCI ☐ OTHER

Name:……. Signature:……

Date:……