Referral to ARBOR

Date: / /

Please complete all fields so this referral can be processed as soon as possible.

Referral Source	
Agency/ Organisation Name	
Referrer's Name	
Referrer's Profession	
Referring E-mail Address	
Best Contact Number	

Bereaved Person's Details			
Name		**Age**	
Is the Bereaved Person/Parent/Guardian aware of this referral? ***Note: client/parent/guardian must give permission for referral***			Yes ☐ No ☐
Gender	Male ☐ Female ☐	Intersex / Indeterminate ☐ Not Stated or Inadequately Described ☐	
E-mail		**Telephone**	
Do you give permission to leave a message disclosing Anglicare WA's ARBOR?			Yes ☐ No ☐
Address			
Sleeping rough or in non-conventional accommodation?	Y ☐ N ☐	**Details**	
Short-term or emergency accommodation?	Y ☐ N ☐	**Details**	
NDIS Participant	Yes ☐ No ☐	**Health Care Card**	Yes ☐ No ☐
Main Language Spoken at Home			
Marital Status	Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married (registered & de facto) ☐		
Is the Bereaved Person Aboriginal or Torres Strait Islander, Culturally or Linguistically Diverse? Have any particular needs? Please describe:	Yes ☐ No ☐ Unknown ☐		

Mental Health			
Mental Health Diagnosis	Y ☐ N ☐	**Details**	
Medication	Y ☐ N ☐	**Details**	

Psychiatrist Details	Y ☐ N ☐	**Name**	
GP Mental Health Care Plan	Y ☐ N ☐		

Labour Force Status		
Full Time ☐	Part Time ☐	Not Applicable – not in the labour force ☐

Suicidality				
No Disclosed Suicidal Ideation/History	☐			
Suicide Attempts	**Dates**			
	Details			
Suicide Ideation	Yes ☐ No ☐	**Safety Plan Attached**	Yes ☐ No ☐	
Additional Information				

Details of Deceased (if known)			
Name of Deceased			
Bereaved Person's Relationship to Deceased			
If bereaved person is under 18, please provide parental/guardian's contact name			
Gender	Male ☐ Female ☐	Intersex / Indeterminate ☐ Not Stated or Inadequately Described ☐	
Date of Death	/ /	**Age**	

Other Agencies Involved	Yes ☐ No ☐	**Please provide details:**

Client Referral Consent			
Consent to liaise with referral source			
Name			
Signature		**Date**	/ /
Consent for ARBOR to make appropriate referral/s to other service providers			
Name			
Signature		**Date**	/ /

Please e-mail this completed form to: info@anglicarewa.org.au