

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? <i>Note: client/parent/guardian must give permission for referral</i>				Yes ☐ No ☐
Gender	Male ☐ Intersex / Indeterminate ☐ Female ☐ 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 ☐	Intersex / Indeterminate ☐	
	Female ☐	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