

# INTERAGENCY REFERRAL

If you need further assistance contact HELP on:  
**0800 623 1700**



**DATE:**

**REFERRAL FROM:**

## CLIENT INFORMATION:

**NAME:**

**ADDRESS:**

**DOB:**

**ETHNICITY:**

**GENDER:** Female

**PHONE:**

**ALT CONTACT:**

**EMAIL:**

**POLICE STATION:**

**DISABILITY AND ACCESS NEEDS:**

**CURRENT PRESENTATION:**

(REASON FOR REFERRAL, WHAT IS HAPPENING FOR THE CLIENT NOW, WHAT SUPPORT IS NEEDED)

**ACTIONS TAKEN:** (POLICE PROCESS, MEDICAL, COURT, CRISIS SUPPORT)

**CURRENT RISK:** (MENTAL HEALTH, RISK AND MEDICAL CONDITIONS)

**ACTIONS REQUIRED:** (FOLLOW UP, L3, LONG TERM THERAPY ETC)