**REFERRAL** **TO FaCS PROGRAM**

**Individual, Family and Community Support Program**

**FaCS is not a mental health treatment program.**

[facs.referrals@mscwa.com.au](mailto:facs.referrals@mscwa.com.au)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | | | |
| **Family Name** | | | | | | **Given Name** | | | | |
| **D.O.B.** | | | | **Age** | | **Gender Identity**  **Pronouns** | | | | |
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| **CONTACT INFORMATION** | | | | | | | | | | |
| **Address** | | | | | | | | | | |
| **Suburb** | | | | | | | | **Postcode** | | |
| **Mobile** | | | | | | | | **Best time to contact** | | |
| **Email** |  | | | | | | | | | |
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| ***LANGUAGE/S SPOKEN Please fill in all the following details*** | | | | | | | | | | |
| **Language/s Spoken** | | | | **Preferred Language** | | | | | | |
| **Interpreter Needed** *Yes*  *No* | | | | **Is there a preference for interpreter?**  *Yes* (**Please indicate):** *Female*  *Male* /  *No* | | | | | | |
|  | | | | | | | | | | |
| **COUNTRY OF ORIGIN** | | | | **Date of Arrival** | | | | | **Visa Type** | |
|  | | | | | | | | | | |
| **FAMILY INFORMATION** | | | | | | | | | | |
| **Relationship status:** | | | | **Married**  **Separated**  **Defacto**  **Partner** | | | | | | |
| **Number of dependents including children:** | | | | | | | | | | |
| **Name of the father of child/ren:**  **DOB of father of child/ren:**  **Contact number of father of child/ren:** | | | | | | | | | | |
| **Child’s family name** | | **Child’s surname** | | | **Gender Identity** | | **Date of Birth** | | | **Relationship to client** |
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| **REASON FOR REFERRAL *Please complete in as much detail as possible.*** | | | | | | | | | | |
| * What are the referrer’s expectations of this service? * What are the client’s expectations of this service? * Does the client currently have a diagnosis for mental illness? * Is the client receiving treatment from a mental health service? * Does the client have any medical or physical illness or disability? * Does the client have any settlement related issues, including issues with visas? * Does the client have any housing related issues? * Do you have any safety concerns for the client? * Any other relevant information. | | | | | | | | | | |
| **Priority** *Yes*  *No* | | | **Reasons why this referral should be given priority?** | | | | | | | |
|  | | | | | | | |  | | |
| **REFERRING PERSON** | | | | **Agency/Role** | | | | | | |
| **Contact number** | | | | **Email** | | | | | | |
| **Has the client given their informed consent to this referral?** *Yes*  *No*  **Date of Referral:** | | | | | | | | | | |
| **SERVICES SOUGHT** | | | | | | | | | | |
| Individual counselling?  Couples counselling?  Referral to other MSC programs e.g. Jobs skills, Housing, Aged Care, Disability, Groups?  Referral to external service or agency? | | | | | | | | | | |

Please email new referrals to [facs.referrals@mscwa.com.au](mailto:facs.referrals@mscwa.com.au)

**For urgent mental health support or intervention please contact your local emergency department, community mental health service or call 000.**