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

**Individual, Family and Community Support Program**

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

facs.referrals@mscwa.com.au

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| --- |
| **CLIENT DETAILS** |
| **Family Name**  | **Given Name**  |
| **D.O.B.**  | **Age**  | **Gender Identity****Pronouns** |
|  |
| **CONTACT INFORMATION** |
| **Address**  |
| **Suburb**  | **Postcode**  |
| **Mobile**  | **Best time to contact**  |
| **Email** |  |
|  |
| ***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

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