

Referral/ Request for Service

Referral Date: / /

Review Date: / /

Feedback Requested: Yes No

To Whom:

By When:

Referral to:
Name: Gamblers Help at Bethany Community Support
Address: 1 Gibb St, North Geelong
Phone: 52788122
Fax: 52786382
Email: gamblershelp@bethany.org.au
Service Type Requested:

Referring Professional:
Name:
Organisation:
Address:
Phone:
Fax:
Email:

Person's details

Name: _____

Date of Birth: / / _____

Preferred name/s: _____

Sex: Male Female

Title: Mr Mrs Ms Miss

Address: _____

Phone: _____ Work: _____

Mobile: _____

Email: _____

Indigenous Status: _____ Preferred Language: _____ Interpreter Required: Yes No

Reason for initial presentation to your service

Reason for referral (gambling behaviour, triggers, comorbidities etc.)

Other notes (eg current services, other issues)

Consent to verbal referral and sharing of relevant information: Yes

Alternatively, attach Client Consent Form.