

# Referral/ Request for Service

Referral Date: / /

Review Date: / /

Feedback Requested:  Yes  No

To Whom:

By When:

<b>Referral to:</b>
Name: Gamblers Help at Bethany Community Support
Address: 1 Gibb St, North Geelong
Phone: 52788122
Fax: 52786382
Email: <a href="mailto:gamblershelp@bethany.org.au">gamblershelp@bethany.org.au</a>
Service Type Requested:

<b>Referring Professional:</b>
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.