



# Billabong Clubhouse Referral Form

## Referrer Details

Who is making this referral?     Self Referral     Family/Carer     Service Provider

Please fill in the applicable details below:

Name:

Phone:

Job Title:

Organisation:

## Consent

Please indicate whether the person you are referring has consented to this referral:

## Person Being Referred

Full Name:

DOB:

Address:

Phone:

Gender:

Identifies as Aboriginal and/or Torres Strait Islander?

Identifies as Culturally and Linguistically Diverse?

Is the person an NDIS participant?

## Supporting Information -Reason for referral?

### Supporting Assessments/Information

Please attach any information you think may be relevant to this referral. Include **health information, support plans, discharge summaries, history of violence and mental health plans and diagnosis.**

## Referral Process

Send this completed form via email to:

[support@billabongclubhouse.org.au](mailto:support@billabongclubhouse.org.au)

Once received, we will follow up with you as the referrer to acknowledge receipt of the referral



NSW  
GOVERNMENT

Health  
Hunter New England  
Local Health District