Melaleuca Australia

Service Referral & Registration Form

PROGRAM BEING REFERRED TO (TICK ONE OR MORE THAT APPLY)

- ☐ Humanitarian Settlement Program
- ☐ Youth Services
- ☐ Health Support Services
- ☐ Settlement Support Services
- ☐ Family and Child Development Services
- ☐ Counselling Services
- ☐ Other (please specify): _____

Please email referrals to referral@melaleuca.org.au

CLIENT DETAILS

Family name:			
Given names:			
Gender:	☐ M ☐ F ☐ Intersex/indeterminate ☐ Not stated		
Date of birth:		Estimated or false? ☐ Yes ☐ No	
Marital status:	☐ Single ☐ Married ☐ Partnered ☐ Child		
Number of children:	*(Please fill out children's details below if living with primary client.)*		
Address:			
	☐ Homeless or at risk of being homeless		
Telephone/s:		Is it safe for us to: ☐ Call ☐ Text ☐ Email	
Religion	☐ Prefer not to say		
Country of origin:			
Ethnicity:		Date of arrival:	
Visa type:	*(Specify type and number)*		
Preferred language/s:		Interpreter required:	☐ Yes ☐ No
Disability:	☐ Yes ☐ No Type of disability:		
Have you fled war or persecution prior to arrival in Australia?			☐ Yes ☐ No

CHILD/REN NAME	GENDER	DOB

EMERGENCY CONTACT DETAILS

Name:	
Phone:	
Relationship:	

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PARENT/GUARDIAN DETAILS IF CLIENT IS UNDER 15 YEARS OF AGE	
Name:	
Phone:	
Address:	
Consent to Melaleuca to provide service for child/youth:	☐ Yes ☐ No
Signature of parent/guardian:	

A young adult over the age of 15 can provide their own consent to receive Melaleuca services providing they have no impairment or disability that would question their ability to do so. Where possible, Melaleuca will always partner with parents in the best interests of their children.

YOUNG ADULT AGED 15 OR MORE	
Consent to contact parents to inform Melaleuca involvement:	☐ Yes ☐ No
Name of parent/s:	
Parent/s phone:	
Parent/s address:	
Signature of client providing consent:	

REFERRAL DETAILS	
Date:	
Referring organisation/self:	
Name of worker:	
Telephone/s:	
Email:	
Consent provided from client to make referral:	☐ Yes ☐ No

Additional comments regarding what kinds of support are expected from this referral:

OTHER SUPPORTS/AGENCIES INVOLVEMENT (WITHIN THE LAST 12 MONTHS)	
Name of support/agency (e.g. NDS etc.)	
Contact person:	
Contact details:	
Name of support/agency (e.g. NDS etc.)	
Contact person:	
Contact details:	

TO BE COMPLETED BY MELALEUCA SERVICES STAFF			
Date of referral:		Received by:	
Program and worker allocation:			

NB: This referral can remain valid for 6 months after the client has exited the program.

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