

National Association for Loss & Grief (NSW) Inc

NALAG Coffs Coast Branch



Please FAX completed form to: 02 6648 3691 OR Phone 02 6648 3675

Referral Form

Personal Information

<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	Family Name:	Given Name:	Other Given No:				
* If referral is for a minor please provide Parent/Guardians name/s below:					Birth date:	Age:	Sex:
Family Name:	Given Name:	Relationship to person referred:	/ /			<input type="checkbox"/> F <input type="checkbox"/> M	
Street address:			Town:	State	Postcode:		
Mobile Phone No:		Home Phone No.:		Work Phone No:			
PO Box:	Email Address:			Occupation:			

Statistics

Self Referral	Group Referral	Aboriginal or TSI	Disabled:	CALD:	Suitable for Seasons for Growth	Notes:
YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	

Mental Health

Mental Health Issue:	Condition:	Diagnosed:	Medication:	Suitable for Blue Healers:	Notes:
YES/NO		YES/NO	YES/NO	YES/NO	
Is the client seeking assistance from any other agency or practitioner:			YES/NO		
List agencies/practitioner's name:				Phone No:	

Referring Agency Information

Is the client aware of the referral? YES/NO	Referring Agency:	
Caseworkers Name:	Phone No:	Fax Phone No:

Current Situation

Losses: (Please circle) Death / Divorce / Separation / Pet / Financial/ Other...	Date of Death of the deceased: / /	Are there any legal issues:
Current situation/Background information		

Office Use Only

Date referral received: / /	Referral taken by:	Referral Accepted: YES/NO (see notes)	Referral Form Faxed to NALAG Centre for Loss & Grief DUBBO for assessment / /	Date Volunteer Contacted: / /	Database Updated:	Referral No: /
No of visits:	Date finalised: / /	Volunteer's Phone No's:			Name of Volunteer/Counsellor assigned:	

Notes:

