CQ FINANCIAL COUNSELLING SERVICE

REFERRAL FORM

CLIENT DETAILS	
Name:	
Address:	
Date of birth:	
Phone:	**May we leave a message?** ☐ **Yes** ☐ **No**
Email:	
Gender: ☐ **Male** ☐ **Female** ☐ **Non-Binary** ☐ **Not Stated** ☐ **Other**	
Marital Status: ☐ **Single** ☐ **Married** ☐ **De facto** ☐ **Divorced** ☐ **Separated**	
Household Composition ☐ **Single (person living alone)** ☐ **Sole parents with dependents** **Ages:** ☐ **Couple** ☐ **Couple with dependent (s)** ☐ **Group (related adults)** ☐ **Group (unrelated adults)** ☐ **Homeless/No Household** ☐ **Not stated**	
Cultural Background: ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal and Torres Strait Islander** ☐ **South Sea Islander** ☐ **Other Please specify**	
Does the client identify as having one or more of the following impairments? ☐ **Intellectual Learning** ☐ **Psychiatric** ☐ **Sensory/Speech** ☐ **Physical/diverse** ☐ **Other**	

CQFCS
CQ FINANCIAL COUNSELLING SERVICE

MAIN SOURCE OF INCOME:

☐ **Employee salary/wages** ☐ **Self-employed** ☐ **Government payments/pensions/allowances**

☐ **Other income including superannuation and investments** ☐ **No Income/Not stated**

Reason/s for referral:

Requesting support with: (please tick all appropriate boxes)

☐ **Financial Counselling** ☐ **Emergency Relief** ☐ **SPER WDO** ☐ **NILS Program**

Experience of Domestic/Family Violence? ☐ **Yes** ☐ **No**

REFERRAL AGENCY DETAILS

Referral agency:

Referral agency contact person/details:

Previous contact with the service? ☐ **Yes** ☐ **No**

CLIENT RELEASE OF INFORMATION

I, …….. (full name of client) give permission to…… (referring service) to provide my details to Central Queensland Financial Counselling Service.

OR

Verbal Consent provided by client ☐ **Yes**

Central Queensland Financial Counselling Service
Address: Shop 2/72 High St Berserker, QLD, 4701 **ABN**: 41 510 210 402
Phone: 074928 1844 **Website**: www.cqfcs.com **Email**:info@cqfcs.com