

REFERRAL TO THE PERTH FAMILY RELATIONSHIP CENTRE

Section 1: General Practitioner details

Name:

Address:

Phone:

Fax:

Date of Referral:

Section 2: Client details (Party A)

Name:

Home Phone:

Mobile:

Is an interpreter required? No Yes If yes, please specify:

Number of Children:

Relationship to Children:

Section 3: Other Party (Party B)

Name:

Home Phone:

Mobile:

Is an interpreter required? No Yes If yes, please specify

Relationship to Party A

Section 4: Safety Concerns

Are there any safety concerns between anyone involved? No Yes

If yes, please specify:

Section 5: Disclaimer

I understand a referral to the Family Relationship Centre is being made on my behalf, and I am aware my details will be faxed to Program staff. A brief explanation of the program was also provided to me.

Name:

Signature:

Section 6: General Practitioner must complete

Please tick all that apply

- Considering Separation
- Separated
- Spending time with Children
- Relationship Concerns

Once complete please fax this form back to Perth Family Relationship Centre on 92784099