Pilbara Community Legal Service Inc.

CLIENT REFERRAL FORM

Date_____

From (Referring Agency/ Referrers Name):	
Phone:	Is the client aware of referral and agreeable to it? Yes No

Service required: (Please tick the relevant boxes)

- ☐ Tenancy Advocate
- ☐ Financial Counselling
- ☐ Legal
- ☐ Housing Support
- ☐ Redress
- ☐ Disability Advocate
- ☐ Domestic Violence
- ☐ Migrant Services

Client's Information

Surname:_____ First Name:_____

Date of Birth:_____/_____/_____Country of Birth: _____

Address:_____

Mob:_____Email:_____

Ethnicity (please circle): Aboriginal CALD Other

Child/ren names and Date/s of birth

Does the client have any Disabilities? (please circle): Yes No

If Yes, please specify: _____

Supporting Information (reason for referral):

Name/s and DOB of other party/s or related party/s (ie partner)

_____

_____

_____

Please email your completed form to:
Karratha/ Roebourne - admink2@pcls.net.au
Hedland/ Newman - adminsh@pcls.net.au