|  |  |  |
| --- | --- | --- |
| **Person referring** |  | |
| **Individual being referred** |  | |
| **Community / House No.** |  | |
| **Phone No.** | | **Alternate contact i.e. Email, phone:** |
| **Program Area:**    *Please only select one or two priority areas for your client.* | * Alcohol and Drug Education (Including counselling) * Child Health * Environmental Health * First Aid and Skin * Healthy Lifestyles (Smoking Cessation) * Mums & Bubs (Pregnancy Health) * Nutrition * Physical Activity * Sexual Health - Male * Sexual Health - Female * Spiritual Health/SEWB | |
| **Reason for Referral:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for Nindilingarri Cultural Health Staff to contact me to discuss the above further.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Preferred Day/Date you would like the NCHS service/visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Please use this form to obtain permission from and refer individuals to the Nindilingarri Cultural Health Services Health Promotion Team. The individual must give consent by signing the form in order for us to contact them.**

Please place referral in an envelope and deliver to NCHS reception or email to: psmanager@nindilingarri.org.au