|  |  |  |
| --- | --- | --- |
| **Referral to the Ethnic Communities Council of Queensland (ECCQ)**  **Viral hepatitis & HIV education and testing support** *(please ask for consent before making referral)* | | |
| **Details of referrer**  Referral date:  Contact person:  Name of organisation/clinic:  Phone: Mobile:  Email: Fax:  **Client details**  Name: Age: Gender:    Phone: Mobile:  Email:  Preferred contact method:  Language spoken: Country of Origin:  Is an interpreter required: Yes/No Preferred gender of interpreter: Male/Female  Support person (a family member or friend/other) can be contacted: Yes/No  If yes, please provide details:  Any issues for support identified by the referrer or client?      Support received from other agencies, if any (e.g. housing, transport, counselling):  **Please email the completed form to** [**referrals@eccq.com.au**](mailto:referrals@eccq.com.au) **or**  **Fax: 07 3846 4453**  Ethnic Communities Council of Queensland, 261 Boundary Street, West End, QLD 4101  [www.eccq.com.au](http://www.eccq.com.au) | | |

**HIV/Aids, hepatitis & Sexual health program**