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| **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/NoIf 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** **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**