WELLINGTON ABORIGINAL CORPORATION HEALTH SERVICE
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SOCIAL & EMOTIONAL WELLBEING TEAM

Service Providers Referral Form

A culturally safe place to provide holistic care from a multi-disciplinary team.

CLIENT'S DETAILS

Name:

Date of Birth: / / Age: Sex: M F

Address:

Client attends: Day care Preschool School at

Medicare Number: Reference No.: Expiry:

Client is: Aboriginal or Torres Strait Islander Neither

PARENT/ CARER DETAILS

Name: Relationship to child:

Address:

Phone: *mobile* *home* *work*

email:

REFERRER'S DETAILS

Name of person completing form: Date: / /

Organisation or Service provider

Phone: Email:

REASONS FOR REFERRAL

WHAT SERVICES DOES YOUR CLIENT REQUIRE?

Counselling Family Violence Mental Health Support Schooling Support

Transition to School Alcohol & Other Drugs Social & Emotional Support Group Support

PARENT/ CARER CONSENT

Has the parent/ carer of the child consented to this referral? No Yes – If Yes, how?

Verbally – by phone In Person – Parent/ carer signature