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SOCIAL & EMOTIONAL WELLBEING TEAM

Adult 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:

Phone: *mobile* *home* *work*

email:

Best times to contact:

Medicare Number: Reference No.: Expiry:

Client is: ☐ Aboriginal or Torres Strait Islander ☐ Neither

REFERRER'S DETAILS

Name of person completing form: Date: / /

Organisation or Service provider:

Position of person referring (if applicable):

Phone: Email:

REASONS FOR REFERRAL (must complete)

WHAT SERVICES ARE REQUIRED?

☐ Counselling ☐ Family Violence ☐ Mental Health Support ☐ Schooling Support

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

ARE THERE ANY OTHER SERVICES CURRENTLY WORKING WITH THE CLIENT?

☐ No ☐ Yes – If yes, please list below

CLIENT CONSENT

Has the client consented to this referral? ☐ No ☐ Yes – If yes, how?

☐ In Person – Client signature: Date: / /

☐ Verbally – by phone

Referrer's signature: Date:

SEWB STAFF USE ONLY

Date referral received: / /

Referral: ☐ Internal ☐ External

Type of referral:

Team Member Allocated:

Initial contact made with client?: ☐ No ☐ Yes Date: / /