WELLINGTON ABORIGINAL CORPORATION HEALTH SERVICE
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SOCIAL & EMOTIONAL WELLBEING TEAM

Child 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:

Best times to contact:

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

PARENT/ CARER CONSENT

Has the parent/carer of the child consented to this referral? ☐ No ☐ Yes

Parent/carer signature: _____ Date: / /

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: / /