Tharawal
Aboriginal Corporation

SOCIAL AND EMOTIONAL WELLBEING TEAM REFERRAL

SOCIAL & EMOTIONAL WELLBEING

CLIENT DETAILS

Name: _____

Address: _____

Phone no: _____ Date of birth: _____

Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Defacto ☐ Divorced ☐

Background: Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Other, please specify _____

Next of kin or contact person: _____

Address: _____

Phone: _____

REFERRAL DETAILS

Referral agency: _____

Referral agency contact person/details: _____

_____

Previous contact with the SEWB team: Yes ☐ No ☐

When and what services were provided: _____

_____

_____

_____

Reason for this referral: _____

_____

_____

_____

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Broadly, what programs/activities do you need to access?

Healthy lifestyles (Dietitian) ☐ Alcohol / other Drugs ☐ Mental health ☐

Social support ☐ Bringing Them Home ☐ Home Support ☐

Other (please specify): _____

Service requested: e.g. MH assessment, AOD review, social support etc.

_____

_____

_____

Additional comments:

_____

_____

_____

_____

_____

_____

_____