SOCIAL AND EMOTIONAL WELLBEING TEAM REFERRAL

Please Note: All community members referred must have Confirmation of Aboriginality.

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 ☐

Do you have a current MHCP: Yes ☐ No ☐

Other, please specify _____

Next of kin or contact person: _____

Address: _____

Phone: _____

REFERRAL DETAILS

Consent given for referral: Yes ☐ No ☐

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:

_____

_____

_____

_____

_____

_____

_____

Office Use Only		
Date of referral received:	Service referred to:	Referral Accepted Yes ☐ No ☐ Date: _____

Completed referrals can be e-mailed to sewb@tacams.com.au