

# 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: \_\_\_\_\_

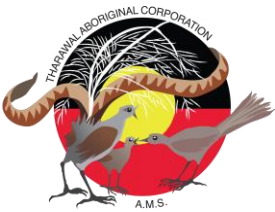
\_\_\_\_\_

\_\_\_\_\_

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.

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**Additional comments:**

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Office Use Only		
Date of referral received:	Service referred to:	Referral Accepted Yes <input type="checkbox"/> No <input type="checkbox"/>
		Date: _____

Completed referrals can be e-mailed to [sewb@tacams.com.au](mailto:sewb@tacams.com.au)