SERVICE REFERRAL FORM

**Please note if crisis assistance is required, please contact Emergency Services on 000 or your local Mental Health Service Acute Care Team.*

Referral Date:		**Client or Parent/Guardian/Carer consent for this referral** *(if aged 12-18):* ☐ Yes ☐ No

REFERRER DETAILS

Name of referrer:		**Organisation:**		
Referrer position/ profession:		**Provider number:** *(if applicable)*		
Phone:		**Email:**		
Address:				☐ Experiencing homelessness

CLIENT DETAILS:

Name:		**Preferred Name**	
D.O.B.		**Gender:**	
☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither**		☐ **Culturally & Linguistically Diverse Background**	
Address:			
Phone numbers:			
Email:			
Parent/Carer/ Guardian Name: *(if aged 12-18)*		**Relationship to youth:**	
Contact details:			

ADDITIONAL INFORMATION:

Reason for Referral:			
Client goals and hopes:			
Key Issues identified by client and worker:	☐ Psychological support ☐ Physical health ☐ Housing/Accommodation ☐ Substance use ☐ Financial ☐ Employment	☐ Relationships ☐ Domestic & Family Violence ☐ Social ☐ Education ☐ Isolation	☐ Other:
Mental Health Diagnosis: *(if applicable)*			

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Mental Health Care Plan completed:	☐ Yes (please attach) ☐ No
Medication details: *(if applicable)*	
Outcomes/scores of any relevant psychosocial assessments: (*e.g. K5, K10, SDQ*)	
Risk of harm to self:	Is the person currently self-harming ☐ Yes ☐ No Is the person at increased risk of suicide ☐ Yes ☐ No **If assessed at high risk of suicide please contact Emergency Services on 000 or Mental Health Service Acute Care Team*
Are there any risk factors we should be aware of?	☐ No ☐ Yes (please specify below or attach existing risk assessment)
Other services client is accessing:	
Other relevant information:	

CLIENT PREFERENCES

Preferred Gender of Worker:	☐ Female ☐ Male
Preferred contact method:	☐ Mobile ☐ Home phone *Ok to leave voicemail/send SMS: ☐ Yes ☐ No ☐ Email ☐ via Referrer ☐ Home visit
Other preferences:	

This form can be delivered to Wakai Waian Healing by:

Fax: 07) 4829 4011, **Email:** referralsti@wakai-waian.com.au, **Postal:** P.O. Box 767, Thursday Island, QLD, 4875.
In person: Unit 3, 40 Douglas St, Thursday Island QLD, 4875.

Further Information:
Freecall: 1800 732 850 or Email: enquiries@wakai-waian.com.au

OFFICE USE ONLY	Date	Initials	Notes
Confirmation sent to Referrer			
Entered on RediCASE			
Referrer notified of referral outcome			