*\*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)* | |  | | | | | | | | |
| **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](mailto: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](mailto:enquiries@wakai-waian.com.au)

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