*\*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 NoIs 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

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