SOCIAL HEALTH REFERRAL

Kalwun's Health Service offers a Social Health Program for Aboriginal and Torres Strait Islander people suffering from mental health illness and/or substance misuse disorders. The program offers case management and care coordination support and works to improve the social and emotional wellbeing of individuals and reduce the harm associated with social and emotional wellbeing, suicide ideation/attempts and alcohol and other drug (AoD) use.

To be eligible for Kalwun Social Health Team, a person must:

1. Identify as an Aboriginal and/or Torres Strait Islander person, be a partner/parent/carer of an Aboriginal and/or Torres Strait Islander person and reside within the Gold Coast region.
2. Want support to address any problems with their mental health and/or misuse of alcohol and other drugs that is impacting on their life.
3. Give consent for the referral.

Client Details

Surname		**Gender**	☐ **Male** ☐ **Female** ☐ **Other**
Given Name(s)		**DOB**	
Street Address	Street: Suburb: State: P/Code:	**Preferred Method of Contact**	Phone Call ☐ SMS ☐ Email ☐
Contact Phone Number		**Email**	
Next of Kin	**Name:**	**Relationship:**	**Contact Number:**

Does the client identify as: ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Non-Indigenous**

Does the client have:				
	GP Mental Health Care/Treatment Plan?	Yes ☐	No ☐	Not Known ☐
	NDIS Package?	Yes ☐	No ☐	Not Known ☐
	Health Care Card?	Yes ☐	No ☐	Not Known ☐

Does the client have a regular/nominated GP?	☐ No	☐ Yes	GP Name:	Practice:
			Email:	Ph. Number:

Referrer Information

Referral Date:	**Name:**	**Role:**
Org. Name :	**Email:**	**Phone:**

Service(s) / organisations that the client is currently engaged with or has been referred to; E.g. Kalwun Child & Family, Public Mental Health Continuing Care Team, Alcohol and Other Drug Services, Private Psychiatrist, psychologist	

Client Circumstances

Reason for Referral: ☐ Social Health Team ☐ Child Psychologist **(15yrs & under)** ☐ Adult Psychologist **(15yrs & above)**

What are the current presenting issues?

What types of supports is the client requiring?

Relevant history: e.g. family dynamics / history, medical, psychiatric, housing, employment, other relevant facts.

Consent Information

Does the client consent to this referral? ☐ Yes ☐ No

Client Signature: ______________________________ **Date:** __________________

Parent/Guardian/Carer Signature: ______________________________ **Date:** ______________

If form completed electronically, tick box to confirm that the client is aware of referral and has given verbal consent. ☐

Email completed referral: socialhealth@kalwun.com.au or Fax: (07) 5526 1796

For any enquiries contact the Social Health Team Intake Officer on (07) 5526 1112