Social Health Referral Form

Funded by:

phn GOLD COAST
An Australian Government Initiative

KALWUN

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The Kalwun Social Health Program is a Gold Coast PHN-funded service that provides comprehensive support to **all Aboriginal and Torres Strait Islander individuals and partners/carers of,** residing in the Gold Coast Community. Social Health engages with people struggling with mental health, alcohol, and other substance issues, or who are seeking suicide prevention. Referrals are accepted from individuals, families, health professionals and other community organisations. The Social Health Team works within a social and emotional wellbeing framework and provide clinical and non-clinical casework and case management intervention, ranging from low intensity to severe and complex. The service aims to empower individuals and families to be able to self-manage and make decisions about their physical and mental health at their own pace.

Client Details

Name:

Date of Birth: | **Age:** | **Sex:** ☐ **Male** ☐ **Female** ☐ **Other**

Address:

What is best contact? Mobile: | **Home:** | **Work:**

Email:

Best time to contact:

Medicare Number: | **Reference No.:** | **Expiry:**

Client is:

☐ Aboriginal ☐ Torres Strait Islander

☐ Both ☐ Carer, parent, or partner of First Nation person

Referrers Details

Name of person completing form: | **Date:**

Organisation or Service Provider:

Position of person referring (if applicable):

Phone: | **Email:**

What services are required? (*Must choose one*)

☐ **Social Health** *(Response time 7-10 days)* | ☐ **Social Health – Covid Response** *(Response time 24-48 hours)*

What other services are required?

☐ Counselling ☐ Family and Domestic Violence ☐ Mental Health Support ☐ Centrelink

☐ Alcohol & Other Drug ☐ Social and Emotional support ☐ Homelessness ☐ NDIS

☐ Cultural Supports ☐ Child Safety Involvement ☐ Family Wellbeing ☐ LGBTIQAP+

Are There Any Other Services Currently Working with The Client? (M*ust be completed*)

☐ No ☐ Yes – if yes, please list below:

☐ Public Mental Health Services | ☐ Probation and Parole
(*e.g. acute care team*) *(please provide details i.e. case manager, location etc)*

Reasons for Referral *(Must be completed)*

Alcohol and Other Drugs *(Please fill if client is seeking alcohol and other drug support)*

Primary substance of choice:	Choose a primary item
Secondary substance of choice:	Choose a secondary item
Any other substances? *(Free text)*	
Method of using substances:	Choose an item
If the client Injects, last time they injected:	Choose an item
Supports the client is seeking:	Choose an item

Risk Assessment *(Must be completed)*

Select below: 1 = no apparent risk 2 = low risk 3 = significant risk 4 = serious risk 5 = extreme and imminent risk

Self-Harm / Suicide	Harm to Others	Vulnerability
Please select	Please select	Please select

Client Consent

Has the client consented to this referral? ☐ No ☐ Yes – if yes, how?

☐ **In Person – Client signature:** **Date:**

☐ **Verbal consent**

Referrer's signature: **Date:**