# Social & Emotional Wellbeing Program
# REFERRAL FORM

**Phone:** **Bilinga** 07 5589 6500 **Coomera** 07 5514 7100 **Miami** 07 5526 1112 **Email:** SEWB@kalwun.com.au

The **Kalwun Social & Emotional Wellbeing (SEWB) Program** is a Gold Coast PHN-funded service that provides comprehensive support to **all Australian First Nation individuals and partners/carers,** residing in the Gold Coast community. SEWB Team works within a social and emotional wellbeing framework to support individuals and/or families 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 SEWB Team 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.

**Please note the SEWB Program does not provide crisis or acute intervention.**

## Client Details

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Other

Address: _____ Suburb: _____

What is the best contact? Mobile:_____ Home: _____ Work: _____

Best time to contact: _____ Email: _____

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 the form: _____ Date: _____

Organisation or Service Provider: _____

Position of person referring (if applicable): _____

Phone: _____ Email: _____

## Reasons for Referral *(Must be completed)*

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## What Services Are Required?

☐ Mental Health Support ***K5 assessment must be completed. Pg. 3****

☐ Alcohol & Other Drug Support ****Alcohol and Other Drug Information must be completed. Pg.3****

☐ Suicide Prevention *(Client will be contacted within 3 business days)* ****Risk Assessment must be completed. Pg.3****

**Additionally support required:**

☐ Social & Emotional Wellbeing Yarning | ☐ Cultural Supports | ☐ Care Coordination

## Treatment Goals and Hopes of the Patient *(Must be completed)*

## Is the client accessing and/or referrals made to other services? ☐ No ☐ Yes – please indicate below:

**Mental Health Services**

☐ Psychologist | ☐ Psychiatrist | ☐ Public Mental Health Services (*e.g., acute care team*) | ☐ AOD Service

**Individual / Child and Family Services**

☐ Child Safety | ☐ Child and Family Support Service | ☐ DV Support | ☐ My Age Care ☐ NDIS

☐ Probation and Parole

**Housing**

☐ Homelessness Support | ☐ Dept of Housing | ☐ Homelessness Shelter / Refuge

**Gold Coast PHN Funded Programs**

☐ Psychological Services Program (PSP) | ☐ Plus Social Clinical Care Coordination | ☐ Psychosocial Support |

☐ Youth Mental Health (headspace Early Psychosis, Lighthouse Program, Psychosocial Support LGBTIQAP+)

☐ **Other:**

## Client Consent

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

☐ In-Person – Client signature: Date: _____

☐ Verbally – by phone

Referrer's signature: Client Signature: Date: _____

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## Assessment Tools

**Mental Health and Suicide Assessment Referrals**

### K5 Assessment

**Tick the boxes from a client or clinician's perspective on how the client has been feeling over the last four weeks.**

| | None of the time | A little of the time | Some of the time | Most of the time | All the time |
|---|---|---|---|---|---|
| 1. In the last four weeks, how often did you feel nervous? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. In the last four weeks, how often did you feel without hope? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. In the last four weeks, how often did you feel restless or jumpy? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. In the last four weeks, bout how often did you feel everything was an effort? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. In the last four weeks, how often did you feel so sad that nothing could cheer you up? | ☐ | ☐ | ☐ | ☐ | ☐ |

**Alcohol and Other Drugs Referrals Only**

| **Alcohol and Other Drugs Assessment** | |
|---|---|
| The primary substance of choice: | Choose a primary item |
| The secondary substance of choice: | Choose a secondary item |
| Any other substances? (*Free text*) | |
| Method of using substances: | Choose an item |
| If the client Injects, the last time they injected: | Choose an item |
| Supports patient is seeking: | Choose an item |

**Suicide Prevention Referrals Only**

**Risk Assessment**

Circle 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 |
|---|---|---|
| 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ | 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ | 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ |

**Please ensure *consent has been obtained and relevant assessments above* have been completed.**
**Incomplete referrals will be returned to referrer.**
Please send completed referrals to **SEWB@kalwun.com.au**