SOCIAL HEALTH TEAM REFERRAL FORM

Please send completed referral form to: socialhealth@kambuhealth.com.au

RISK INDICATOR (circle): High Risk — Moderate Risk — Low Risk

SURNAME: ______ GIVEN NAMES: ______

DOB: ___/___/___ M ☐ F ☐ Nationality (circle): Aboriginal / Torres Strait Islander

PHONE (H) ______ (W) ______ (M) ______

CLIENT CONSENT FOR REFERRAL: YES ☐ NO ☐ (**MUST OBTAIN CONSENT**)

CONSENT FOR OTHER SERVICES TO BE INVOLVED YES ☐ NO ☐

CONTACT PERSON: ______ RELATIONSHIP: ______

CONTACT DETAILS: ______

Mental Health Care Plan YES ☐ NO ☐

DIAGNOSIS: ______

MEDICATIONS: ______

REFERRAL TO: Social Health Team – social support ☐ Suicide Intervention ☐

(SPECIFY SERVICE) Mental Health Support ☐ Social Worker - counselling ☐ Social Health Group ☐

REASON FOR REFERRAL (**Identify Risks**):

______

RELEVANT PAST MEDICAL HISTORY/RELEVANT INFORMATION/COMMUNITY/FAMILY SUPPORT:

______

OTHER AGENCIES/COMMUNITY HEALTH SERVICES INVOLVED

______

Office Use Only

Aboriginal	☐	REFERRED BY: ______	
Torres Strait Islander	☐	DATE: ___/___/___	
Aboriginal & Torres Strait Islander	☐	AGENCY: ______	PH: ______
Non-Indigenous	☐		