Central Australian Aboriginal Congress Aboriginal Corporation
PO Box 1604 Alice Springs NT 0871
PH (08) 8959 4780 FAX (08) 89594788 Free Call: 1800 142 900

CONGRESS SEWB SERVICES –– SELF REFERRAL

DATE OF SELF-REFERRAL:……/……/…… CAAC ID::……

MY NAME: CAAC Staff member? YES [ ] NO [ ]	DATE OF BIRTH: ABORIGINALITY: YES [ ] NO [ ]
GENDER:	SKIN NAME (optional):
ADDRESS:	MOTHER'S NAME: MOTHER'S COUNTRY:
MY PHONE NUMBER(S): Home: Mobile:	FATHER'S COUNTRY: MY HOMELAND IS:
EMEGENCY CONTACT & NO:	LANGUAGE(S):
I HAVE TRANSPORT YES [ ] NO [ ]	MY DOCTOR'S (GP) NAME IS:

DETAILS OF SOMEONE WHO TAKES CARE OF ME or NEXT OF KIN (IF APPLICABLE):

Name: Phone:

A. I WOULD LIKE TO TALK TO SOMEONE ABOUT:-

[ ] Drinking / Drugs/ Gunja	[ ] Violence _ Domestic / Family /Cultural
[ ] Money / Centrelink	[ ] Housing [ ] Sadness/Nervousness
[ ] Family	[ ] Job [ ] Other

B. I would like to talk to a psychologist or therapist about my worries.	YES [ ] NO [ ]
My main reason for wanting SEWB is for my problem with Alcohol / Drugs (Circle your choice)	YES [ ] NO [ ]
C. I FEEL LIKE HURTING MYSELF NOW **Important: If <u>YES,</u> go to the Emergency department at Alice Springs Hospital or see your GP now.**	YES [ ] NO [ ]

MY PROBLEMS ARE: 1. 2. 3.

THE MEDICAL PROBLEMS I SUFFER FROM ARE:	
MY PERMISSIONS AND CONSENT	
I would like to receive services from SEWB	YES [ ] NO [ ]
I give permission for SEWB staff to visit me at home.	YES [ ] NO [ ]
I have consented to this referral by phone. (*Please sign this referral form at your first session*).	YES [ ] NO [ ]
The staff member who checked this Self-Referral form is:- Staff Name: Job role:	

Sign your name here:-

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Please read important condition:

If you are under 15 years old, you will require Parent or Guardian or Territory Families to give signed consent.