Central Australian Aboriginal Congress Aboriginal Corporation
PO Box 1604 Alice Springs NT 0871
PH (08) 8959 4750 FAX (08) 89594765 Free Call: 1800 142 900
Email: sewb.referrals@caac.org.au For secure transmission, fax this referral.

CONGRESS SEWB REFERRAL without a MHTP

Please complete ALL sections as missing information will delay the referral being accepted.

REFERRAL DATE: ……/……../…… **CAAC ID::……**

REFERRER: …… **HRN No……..……..**

POSITION:…….. Organisation/Clinic:……..……

CONTACT No:…….. EMAIL: ……..……

Client's Name: **CAAC Staff member? YES [ ] NO [ ]**	**Date of Birth:**
Gender:	**Aboriginality:**
Address:	**Mother's Name:**
	Emergency Contact & no.
Phone Home: **Phone Mobile:**	**Medicare no. & Expiry date:** **Healthcare Card no:**
Client has own transport YES [ ] NO [ ]	**Usual GP:**
Next of Kin or Significant Carer (If applicable):	
Guardianship YES [ ] NO [ ]	**Name of Guardianship Officer:**

CLIENT'S MAIN PROBLEMS (SOCIAL OR MEDICAL) *(details)*

1.

2.

3.

Is "substance abuse" a significant reason for referral (please circle)? YES [ ] NO [ ]

Does this client have a history of a neurological condition or disability? YES [ ] NO [ ]

RISK ASSESSMENT (MUST BE COMPLETED): AT THE TIME OF THIS REFERRAL, THE CLIENT IS AT:-

Risk of self-harm or suicide: High [ ] Medium [ ] Low [ ] Not known [ ]

Risk of harm / violence towards others: High [ ] Medium [ ] Low [ ] Not known [ ]

Additional remarks about risk:

IMPORTANT: ***If at HIGH or MEDIUM RISK, please phone and inform SEWB administrator, 08-8959 4780.***

REFERRED FOR:

A. SIX THERAPY SESSION WITH: (Tick options)

[ ] Allied Health Therapist or Mental Health SW for Focussed Psychological Services

[ ] Psychologist/Clinical Psychologist (Name of psychologist:……)

B. CONSULTATION WITH ABORIGINAL AOD SUPPORT & CARE MANAGER [ ]

C. SOCIAL SUPPORT

[ ] Housing [ ] Financial [ ] Family [ ] Funeral [ ] Complex Issues

D. COGNITIVE/NEUROPSYCHOLOGY TESTING [ ]

CLIENT PREFERS TO WORK WITH STAFF WHO IS Male [ ] Female [ ] Either gender [ ]

CONSENT
[*NB: Clients under 15 years require Parent or Guardian consent,* and clients in foster care require Territory Families (TF) consent. *The referrer is responsible for ensuring the client (age 15 years and above) has the capacity to consent to receiving this service*]
Has the client (age 15 years and over) consented to this referral? YES / NO
Has the Parent or Guardianship Officer or TF officer consented to this referral? YES / NO/ NA
Has the client authorised home visits? YES / NO
Referred by: **Signature:**
Designation: **GP Provider # (if applicable):**

DATE	UNTIL	CURRENT/REGULAR MEDICATION	DOSAGE

ALLERGIES: Adverse Reaction	Reaction	Certainty	Provided by

End