Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Social and Emotional Wellbeing (SEWB) – Referral WITHOUT Mental Health Care Plan

Please email completed referral to sewb.referrals@caac.org.au

Referral Date:
Referrer Name:
Clinic or Program:
Referrer email address:

Client's Name: **Skin Name:**	**Date of Birth:**
CAAC ID:	**HRN:**
Congress Staff Member? ☐ **YES** ☐ **NO**	**Gender:**
Phone Number(s): **Home -** **Mobile -**	**Aboriginality:** ☐ **YES** ☐ **NO** **Language(s):** **Interpreter required?** ☐ **YES** ☐ **NO**
Address:	**Patient has own transport?** ☐ **YES** ☐ **NO** **Client authorised home visits?** ☐ **YES** ☐ **NO**
Medicare Card number:	**Health Care Card number:**
Usual Clinic and GP:	
Next of kin or significant carer:	

Guardianship order in place? ☐ **YES** ☐ **NO**	**Accessing Disability Support Pension?** ☐ **YES** ☐ **NO**
Financial administration (Public Trustee) in place? ☐ **YES** ☐ **NO**	**Accessing NDIS Support?** ☐ **YES** ☐ **NO**

Consent

NB: Clients under 16 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 16 years and above) has the capacity to consent to receiving this service.

Has the client (age 15 years and over) been made aware of the purpose and consented to this referral to SEWB?

☐ **YES** ☐ **NO**

If applicable, has the Parent or TF Guardianship Officer consented to this referral?

☐ **YES** ☐ **NO** Name of person: _____

Referred for:

☐ **Psychologist / Clinical Psychologist**

Option to nominate psychologist: _____

Appointment booked?

☐ **Counsellor / Accredited Mental Health Social Worker**

☐ **Social Support:**

☐ Housing ☐ Financial ☐ Domestic ☐ Funeral ☐ Complex Issues

☐ **Consultation with Aboriginal AOD Care Management Worker**
(If substance use is a significant reason for referral)

☐ **Neuropsychology / Cognitive Testing**

☐ **Psychiatrist Review** - **Dr Marcus Tabart, fortnightly sessions at Leichardt Tce**
(Please include details below about specific purpose of review, e.g. medication review)

Client's primary problems (social, medical or psychological):

1.

2.

3.

<u>For Neuropsychology / Cognitive Assessment:</u>

[These assessments are not valid for inclusion in legal decisions]

Describe background and specify question(s) the assessment is to address:

Nominate someone who is very familiar with the client to provide relevant history:

Verbal consent provided by client to contact the above person for information?

☐ **YES** ☐ **NO**

How is the client's daily life impacted by known or suspected cognitive impairment?

Please include as an attachment to this referral:

- Medical and social history from birth to now (significant events).
- Reports of specialist and medical investigations substantiating medical condition.
- State how you intend to use the report from this assessment.

Risk Assessment

At the time of this referral, the client is at:

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

Include details:

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

Include details:

Risk of harm from others, including DV: High ☐ Medium ☐ Low ☐ Not known ☐

Include details:

Client's goals:

Treatment plan:

(Treatments, actions and support services to achieve client's goals)

Crisis/Relapse plan:

If required, note arrangements for crisis intervention or relapse prevention / management: