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Wungening Aboriginal Corporation
Healing Aboriginal Peoples: Mind, Body and Spirit

REFERRAL FORM

Please ensure all sections are completed and return via email on referral@wungening.com.au

REFERRING AGENCY DETAILS Referral Date: __/__/____

Agency Name:_____

Contact Name:_____ Email:_____

Address_____

Phone: _____

Has this referral been discussed with client? ❒Yes ❒ No

If no, please provide details:_____

CLIENT DETAILS

Name:_____ Date of Birth:_____/_____/_____

Address:_____

Gender ❒M ❒ F Aboriginal/Torres Strait Islander ❒ Other ❒_____

Phone :_____ Mobile:_____ Email:_____

The client give permission to leave a voice and / or send a text message: ❒Yes ❒ No

By signing this form the client consents to being contacted by Wungening and agrees to be added to the data base which is governed by the Privacy Act. I also hereby consent to the Counsellor/Educator within Wungening Aboriginal Corporation obtaining and releasing information (such as attendance and participation) as necessary to the agencies involved in my treatment.

Referrer Signature:_____ Date:_____/____/____

Client Signature:_____ Date:_____/____/____

If the client is under the age of 18 years of age the Parent/Guardian must complete the following.

I consent to my child being seen by a Counsellor/Educator._____*Name,*

_____Address

Parent/Guardian's Signature:_____ Date:_____/____/____

PLEASE NOTE: This referral cannot be actioned without the signature of the Client and or Parent/Guardian

Wungening Aboriginal Corporation will not use or disclose any information to any parties not directly involved in your treatment unless specifically authorised by you. This means if you would like Wungening to speak with family members or significant others on your behalf you MUST nominate them individually in Section listed (below)

Informing family members of my attendance. I understand that what I say during counselling remains confidential.

Name: ..... Relationship: .....

Name: ..... Relationship: .....

CO-LOCATION (AGENCIES) ONLY – The above mentioned referral agency has made the following appointment.

Appointment date:____/____/_____ Time:_____:____hrs Location:.....

Appointment date:____/____/_____ Time:_____:____hrs Location:.....

The details of this appointment are to be included in the *appointment schedule* which is emailed to the AADS Counsellor/Educator and cc: referral@wungening.com.au

REFERRAL DETAILS

Reason for the referral:

_____

_____

_____

SUBSTANCE USE:

PLEASE CIRCLE THE TREATMENT OPTIONS THAT THE CLIENT IS REQUESTING:

Individual Alcohol and Drug Counselling	Drug and Alcohol Family support counselling	Solid Ground Day Program (SGDP)
Withdrawal referral	Residential referral	Advocacy / Support
Unsure client wants to discuss options	Who's Ya Mob Program	

IDENTIFIED RISKS:

- ❒ Self-harm / suicide ideation
- ❒ Drug overdose
- ❒ STI / Blood Borne Virus (BBV)
- ❒ Harm from others
- ❒ Other
- ❒ Aggression / Violence
- ❒ History of unsafe injecting practice
- ❒ Pregnancy
- ❒ Homeless
- ❒ Mental Health Diagnosis

If risk is identified, please provide more information:

_____

_____

Legal Issues:

_____

OTHER CURRENT SERVICES PROVIDING CARE:

Service	Contact person	Contact number	Permission to contact
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No

OFFICE USE ONLY CHECK LIST

URN #	Number of Contacts	Referral Agency Contact Receipt of referral	Referral Agency Contacted –On Progress
Appointment Made:			