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

211 Royal St East Perth WA 6004
PO BOX 8105 PBC WA 6849
ph: 9221 1411 fax: 9221 1585
www.wungening.com.au info@wungening.com.au

AOD SUPPORT – 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		Phone	
Email		Mobile	
Address		Suburb	
Has this referral been discussed with client?		☐ yes	☐ no
If no, please provide details			

Client Details				
Name		Date of Birth		
Address		Suburb		
Email		Phone		
Gender	☐ Male ☐ Female	Mobile		
Aboriginal and/or Torres Strait Islander	☐ yes	☐ Other		
The client gives permission to leave a voice and / or send a text message			☐ yes	☐ no
Preferred Location for Counselling:				
☐ Armadale	☐ East Perth	☐ Midland	☐ Mirrabooka	☐ Rockingham

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)*, of

__________ *(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 (see next page)

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

CO-LOCATION (AGENCIES) ONLY

The above mentioned referral agency has made the following appointment:

Date		Time		Location	

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

REFERRAL DETAILS

Reason for the Referral:

Substance Use:

Which treatment options is the client requesting?

- ☐ Individual AOD Counselling
- ☐ AOD Family Support Counselling
- ☐ Solid Ground Day Program
- ☐ Withdrawal Referral
- ☐ Residential Referral
- ☐ Advocacy / Support
- ☐ Who's Ya Mob Program
- ☐ Phone Counselling (UTurn)
- ☐ Unsure, client wants to discuss options

Identified Risks?

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

If risk is identified, please provide more information:

Is the client currently engaged in other AOD support? ☐ yes ☐ no

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	Referral Agency Contacted – on Progress
Appointment made:		Receipt of Referral	