**SOCIAL HEALTH PROGRAM INITIAL REFERRAL**

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| Kalwun Health provides a clinical social health and alcohol and other drug service to the Gold Coast Aboriginal and Torres Strait Islander community. Kalwun can support individuals with a wide range of needs and will endeavour to assist those in need through the delivery and provision of quality support, both at the Kalwun Health Service and in the Community. To be eligible for Kalwun Social Health Service, a person must:   1. Identify as an Aboriginal and/or Torres Strait Islander person, be a partner/parent/carer of an Aboriginal and/or Torres Strait Islander person 2. Reside within the Gold Coast 3. Be over the age of 12 (\*special consideration may be applied to people under 12yr of age) 4. Give consent for the referral |

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| **Client Details** | | | | | | | |
| **Surname** |  | | | | **Sex** | Male  Female  Other | |
| **Given Name(s)** |  | | | | **DOB** |  | |
| **Address** | Street:  Suburb:       State:    P/Code: | | | | | | |
| **Contact Phone Numbers** | Home | | | Work | | | Mobile |
| **Health Care Card** | Yes  No  Not Known | | | | | | |
| **Does the client identify as a person of Aboriginal and/or Torres Strait Islander descent?**  Aboriginal  Torres Strait Islander  Both  Non-Indigenous | | | | | | | |
| **Does the client have a GP Mental Health Treatment Plan?** YesNo  I**s the plan attached to this referral?** YesNo | | | | | | | |
| **Does the client have a regular/nominated GP?** | | No | Yes - GP Name:  Practice:       Ph Number: | | | | |

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| **Referrer Information** | |
| **Referral Date** |  |
| **Referred By** | **Name:**  **Role:** |
| **Organisation** | **Name:**  **Phone:**  **Email:** |
| **Service(s) / organisations that the client is currently/has previously been engaged with:** |  |

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| **Client Circumstances** | |
| **Reason for Referral:**  Mental Health Issues  Drug and Alcohol Misuse  Cultural Issues | Suicide Prevention & Recovery Management - **Non Acute**  Self Harm  Facilitate & support engagement with other services  Clinical case management in collaboration with GP |
| **Details:** include expectations of service. | |
| **Relevant history:** e.g. family dynamics / history, medical, psychiatric, housing, employment, other relevant facts. | |

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| **Consent Information** |
| Kalwun Social Health Program and Krurungal work as part of an Aboriginal and Torres Strait Islander Integrated Mental Health and Alcohol and Other Drug Support Service on the Gold Coast.  **Does the person consent to the sharing of information between the Kalwun Social Health and Krurungal?**  YesNo  **Does the client agree and provide consent for the Kalwun Social Health and Krurungal to refer their information and contact other services on their behalf?**   YesNo  **Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If form completed electronically, tick box to confirm that the client is aware of referral and has given verbal consent. |

**Send the completed referral to:** Email: [socialhealth@kalwun.com.au](mailto:socialhealth@kalwun.com.au) Fax: (07) 5526 1796