CWAATSICH
Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited

SOCIAL AND EMOTIONAL WELLBEING
STOP THE SILENCE
Chat with the CWAATSICH SEWB Team

CWAATSICH
Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited

SEWB Intake Referral Form

All referral to be submitted by email to: sewbintake @cwaatsich.org.au

Referring AGENCY/SERVICE			
Agency/Service		**Telephone No**	
Address		**Fax No**	
Name of Referring Officer		**Email Address**	

Patient's Name		**Date of Birth**	
Address		**Phone** **Email**	
Carer and/or Parent Guardian contact details		**Care Plan**	
		GPMP Yes ☐ No ☐ Date / / MHCP Yes ☐ No ☐ Date / / TCA Yes ☐ No ☐ Date / / 715 Yes ☐ No ☐ Date / /	
Ethnicity	☐Aboriginal ☐Torres Strait Islander ☐Non-Indigenous ☐NESB ☐ Other		
Age		**Gender**	☐ *Male* ☐ *Female* ☐ *Transsexual*
Relationship Status	☐Married ☐Spouse/partner ☐ Single		
GP Name		**GP Practice**	
Registered CWAATSICH Client	☐Yes ☐No	**Registered CTG**	☐Yes ☐No
Chronic Disease Client	☐Yes ☐No		

Current Diagnosis			
Depression ☐Yes ☐No	**Anxiety Disorder** ☐Yes ☐No	**Obsessive-Compulsive Disorder (OCD)** ☐Yes ☐No	
Post-Traumatic Stress Disorder (PTSD) ☐Yes ☐No	**Bipolar** ☐Yes ☐No	**Schizophrenia** ☐Yes ☐No	
Psychological Distress Scale	**K10 Y N**	**Dass 21 Y N**	**Stay Strong Y N**

Reason for Referral

____

____

____

____

____

CWAATSICH
Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited

SOCIAL AND EMOTIONAL WELLBEING
STOP THE SILENCE
Chat with the CWAATSICH SEWB Team

CWAATSICH
Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited

Clients Support/Needs Requirements		**Yes**	**No**		**Yes**	**No**
	Psychologist Needs			Relationship Problems		
	Physical Health Needs			Financial Problems		
	Education/Schooling Needs			Child Support		
	Family Problems			Transportation Problems		
	Legal Problems			Confidentiality Concerns		
	Employment Assistance			Other		
	Social Support					

Current Presenting Risks				
Risks to Self	☐ **Nil**	☐ **High**	☐ **Medium**	☐ **Low**
Risks To Others	☐ **Nil**	☐ **High**	☐ **Medium**	☐ **Low**

Current Drug Used

☐ Methamphetamine/Ice ☐ Marijuana ☐ Alcohol ☐ Heroin ☐ Benzos

☐ Cocaine ☐ Methadone ☐ Ecstasy ☐ Other_______________________________

Current Services Client is Accessing

____

____

____

____

____

Clients Consent Signature: ____ Date: / /

Parent/Carer Guardian: ____ Date: / /
(If underage)

Clients request for follow up additional Support/Services

☐ Child & Maternal Health ☐ Clinic Team ☐ Hearing Health Working ☐ Diabetes

Follow up referrals booked and client advised ☐ Yes ☐ No

Staff Name:_________________________________

Staff Signature:_____________________________

Date:______________________________________