SOCIAL & EMOTIONAL WELLBEING (SEWB) – KAWUMA MIRUMA REFERRAL FORM

KAWUMA MIRUMA
Social and Emotional Wellbeing Program

UNGOOROO
Aboriginal Corporation

Please Note: This referral is not accepted until a Kawuma Miruma worker has made direct contact with the referrer via phone, fax or email. If contact is not made by a worker within 3 working days, please call us on (02) 6571 5111.
The aim of Kawuma Miruma is to support people to address social issues that are impacting on their wellbeing. This could be housing, education, employment, lack of mental health support or access to culturally appropriate services.

Ungooroo's Social and Emotional Wellbeing Program is not a crisis service.

If there are immediate mental health concerns for a person, please dial 000 or go to the closest hospital Emergency Department. For urgent concerns call the Mental Health Line on 1800 011 511.

STAFF USE ONLY					
Type of referral:	☐ in person ☐ Fax ☐ Email ☐ Phone				
Date Referral received:		Time:		Received by:	
Date Confirmation Fax sent:		Time:		Sent by:	

Date:	

Section A: DETAILS OF PERSON					
Has the person agreed to this referral? ☐ Yes ☐ No (Please Note: referrals will not be accepted without the consent of the person)					
Is the person Aboriginal or Torres Strait Islander? ☐ Yes ☐ No (Please Note: this program is for Aboriginal and Torres Strait Islander people only)					
First Name:				Surname:	
Date of Birth:		Age:		☐ Male ☐ Female ☐ Other	
Address:					
Suburb:				Postcode:	
Phone:				Mobile:	
Email:					
Which contact/s would the person prefer to use? ☐ Home ☐ Mobile ☐ Email					

EMERGENCY CONTACT			
First Name:		Surname:	
Relationship to Person:			
Address:			
Suburb:		Postcode:	
Phone:		Mobile:	

SOCIAL & EMOTIONAL WELLBEING (SEWB) – KAWUMA MIRUMA REFERRAL FORM

KAWUMA MIRUMA
Social and Emotional Wellbeing Program

UNGOOROO
Aboriginal Corporation

REASON FOR REFERRAL (Social factors that are impacting on wellbeing, any relevant background information)

Section B: DETAILS OF REFERRER			
☐ Self ☐ Family ☐ Friend ☐ Organisation / Service			
First Name of Referrer:		Surname Name of Referrer:	
Organisation:			
Address:			
Suburb:		Postcode:	
Phone:		Mobile:	
Email:			
Does the person see any other services at the moment? ☐ Yes ☐ No			
Please list services accessed in the last 12 months (e.g. medical professionals, mental health, drug and alcohol, community support etc.):			
Does the person have a regular GP? ☐ Yes ☐ No			
GP Name:			
Name of Practice:			
Address of Practice:			
Suburb:		Postcode:	
Does the person have a mental health care plan? ☐ Yes ☐ No (if Yes please attach if possible)			

Please fax or email Referral to:

Email: intake@ungooroo.com.au

Fax: 6571 5777

Phone: 6571 5111