Aftercare Service
REFERRAL FORM

CULTURE CARE CONNECT

CULTURE CARE CONNECT- AFTERCARE SERVICES REFERRAL FORM

The information on this form is strictly PRIVATE & CONFIDENTIAL

Once completed please email this referral to: culturecareconnect@bega.org.au

For any queries please contact (08) 9022 5558 or free-call 1800 037 037 (ask for SEWB)

CLIENT DETAILS		
Full name:		
Date of birth:		
Address:		
Email address:		
Home Number:		Mobile number:
Gender	☐ Male ☐ Female ☐ Other (Pronoun:)	
Do you Identify as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	
REFERRER		
Name of referrer		
Relationship to Client		
Organisation		
Contact details		
Date of referral		
Reason for referral	☐ Plan to attempt suicide ☐ Suicide- Attempt	
Date of attempt	Click or tap enter a date.	
Location of attempt		
Method of attempt		
Was the client under the influence of Drugs and or Alcohol?	☐ Yes ☐ No ☐ Unknown	
Reason for attempt as understood by the client		
Has a safety plan been undertaken	☐ Yes	☐ No: Please provide reason why below
Is the client aware of this referral? ☐ Yes ☐ No		
Has the client consented to this referral? ☐ Yes ☐ No		
How would the client like to be contacted? ☐ Phone ☐ SMS ☐ Email ☐ Letter		

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Medical History (ONLY If relevant to the referral)	
Current Medications	
Substance Use History	
Mental Health History	
Social/Family Situation	
Other agencies currently working with clients?	
Culture Care Connect to complete.	
Referral received:	
Client Referred on (Date):	
To (Name):	

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