# IWC Indigenous Stepped Care Mental Health Referral Form

This form is for:

- Self-referral
- Referrals from a family member or friend
- Referrals from allied health professionals
- Referrals from community organisations

For help completing the form or further information, please get in touch via contact details below.

| Phone | Fax | Email | Website |
|---|---|---|---|
| 1300 492 492 | 07 3811 6459 | Indigenoussteppedcare@iwc.org.au | https://www.iwc.org.au |

## Referrer Details

Referrer Name:

Date of referral:

Referrer organisation *(N/A for self or family referral)*:

Referrer profession OR relationship to client (e.g. social worker, self, carer etc.):

Referrer address:

Referrer phone:

Alternative phone (if applicable):

Referrer email address:

## Client Information

Has the person given consent to be referred for additional supports? Yes No

***If 'No', do not proceed with referral***

Client name:

Date of birth:

Age:

Gender:

Country of birth:

Preferred language:

Interpreter required?

Address:

Suburb:

Postcode:

Client phone:

Alternative phone (if applicable):

Email (if applicable):

Marital status:

## Demographic Information

*Tick if applicable, leave blank if unknown*

| | | | |
|---|---|---|---|
| Rural and Remote resident | ☐ | Culturally and Linguistically Diverse background | ☐ |
| Aboriginal and/or Torres Strait Islander | ☐ | LGBTIQ community member | ☐ |
| Female with Perinatal depression | ☐ | Financially disadvantaged (e.g. concession card holder) | ☐ |
| Affected by Domestic Violence | ☐ | Homeless (e.g. sleeping rough or couch surfing) | ☐ |
| NDIS participant | ☐ | Dept. Veterans Affairs card holder | ☐ |
| Private health insurance | ☐ | Currently employed | ☐ |

## Risk Information

*Tick 'Yes' or 'No' as applicable*

| | | |
|---|---|---|
| Is the person currently experiencing suicidal thoughts? | Yes | No |
| Has there been a past suicide attempt? | Yes | No |
| If yes, was the attempt in the last 7 days? | Yes | No |
| Has the person recently self-harmed, or is there a history of self-harm? | Yes | No |
| Has the person been admitted to hospital for mental ill-health in the last 12 months? | Yes | No |
| Is there a risk of harm to others? | Yes | No |

## Referral Information

Which level of support do you believe the person requires? (Please circle) low / moderate / high

Please provide a brief reason for the referral:

## Additional information

*Please type below or **attach** any additional information that you think is relevant (e.g. a K10+ assessment, mental health support plan)*

## Send completed referrals via:

- **Fax:** 07 3811 6459
- **Email:** Indigenoussteppedcare@iwc.org.au

## Or call to complete over the phone:

- **Phone:** 1300 492 492