National Suicide Prevention Trial
Social & Emotional Wellbeing Program
Referral Form

Date: _____ **Referral Source:** *Self* ☐ *Internal* ☐ *External* ☐ _____

Name: _____ **DOB:** _____

Address: _____ **Post Code:** _____

Contact No: _____ **Email:**

_____ **Cultural Identity:**

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

☐ Non – Indigenous ☐ Other _____

Client's Gender Identity:

☐ Female ☐ Male ☐ SisterGirl ☐ BrotherBoy ☐ Transgender

☐ Gender Queer ☐ Intersex ☐ Other_____

Client's Sexual Identity: ☐ Lesbian ☐ Gay ☐ Bisexual

☐ Heterosexual ☐ Pansexual ☐ Asexual ☐ Other

Criteria for Referral Please Tick:

☐ Aboriginal and/or Torres Strait Islander person who has attempted to end their life through suicide.

☐ Aboriginal and/or Torres Strait Islander person experiencing suicidal crisis.

☐ Aboriginal and/or Torres Strait Islander person or family who have been bereaved by suicide.

Safety Concerns:

Is your client suicidal?	☐ YES	☐ NO
Has your client attempted to take their life through suicide?	☐ YES	☐ NO
Has your client self-harmed?	☐ YES	☐ NO
Has your client been engaging in risky behaviour?	☐ YES	☐ NO
Has your client you been bereaved by suicide?	☐ YES	☐ NO

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Housing

Unit / Flat / House

Is the clients housing stable/unstable?

☐ Own ☐ Private Rental ☐ Dept Housing ☐ Other Housing Agency

☐ Boarding ☐ Caravan ☐ Couch Surfing ☐ Relatives Home

Other: _____

Health and Wellbeing:

Does the client have any Drug and/or Alcohol concerns?

Please outline:

Medical Conditions? _____

_____

Current Medications? _____

_____

Allergies? _____

_____

Which Medical Service Does your Client Attend? _____

Other concerns for Referral:

☐ Family/Domestic Violence ☐ Grief/Loss/Anger ☐ Sexual assault

☐ Education Support ☐ Child Safety Issues ☐ Alcohol & Drug

☐ Illness/Disability ☐ Conflict/ Communication ☐ Homelessness

☐ Cultural Issues ☐ Legal Matters ☐ Transport

☐ Family Support (parenting) ☐ Self Esteem ☐ Income Support

Other: _____

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Family Status:

Significant people _____

Children:

Name_____ DOB_____ ☐M ☐F

Name_____ DOB_____ ☐M ☐F

Name_____ DOB_____ ☐M ☐F

Name_____ DOB_____ ☐M ☐F

Name_____ DOB_____ ☐M ☐F

Relationship to children please circle

☐ Mother ☐ Father ☐ Grandparent ☐ Related/ Kinship Carer ☐ Other

……

* Child Care/School attended by child/ren _____

Support Network / Other Services Involved:

☐ Family: _____

☐ Friends: _____

☐ Workplace: _____

Additional Information: _____

Employment / Income:

☐ Newstart Payment ☐ Home Parenting ☐ Employed (FT / PT / Cas)

☐ Self Employed ☐ Student ☐ Disability Payment

Other Concerns:

Please email completed form to: sewb@kurbingui.org.au

_____ _____ _____

Staff Member **Signed** **Date**