

**Wellbeing Team: Referral form**

**Personal details:**

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| --- | --- |
| Date of referral: |  |
| Name of person being referred:  |  |
| Date of Birth: |  |
| Telephone number: |  |
| Mobile number: |  |
| Address: |  |
| Emergency contact (name, relationship and contact) |  |

**Details regarding the referral:**

|  |  |
| --- | --- |
| Is the client being referred to a specific program?(please circle/highlight)  | * AOD
* Mental Heath
* Post Custodial Support
* Social and Emotional wellbeing
* Unsure of which program would be best suited
 |
| What is the client wanting/needing assistance with?  |  |
| Are there any risks associated with this client that we should be aware of? |  |
| Does this client have any special needs we should be aware of when making contact?  |  |

**Consent and other details:**

|  |  |
| --- | --- |
| Does the client consent to this referral being made? |  |
| Does this client agree for RivMed to make contact to arrange an initial assessment?  |  |
| Are there other services involved in the clients support that they agree for us to contact if required?  |  |

**Referrers details:**

|  |  |
| --- | --- |
| Please include your name, relationship to the client, email and mobile number: |  |

Please send this completed referral form to: wellbeingintake@rivmed.org.au