Referral Form

South Coastal Babbingur Mia Team
Fax (08) 9592 5635
referrals@southcoastal.org.au

South Coastal Health & Community Services is a not-for-profit organisation supporting the health and wellbeing of women and their families in the Rockingham, Kwinana, and Peel region.
Our South Coastal Babbingur Mia Team provides health, social and emotional well-being services to Aboriginal and Torres Strait Islander families in the Rockingham and Kwinana areas.

Client Details		
Date of Referral / /	**DOB** / /	**Age**
Name		**Gender**
Address		
Mobile	**Home**	**Other**
Email		
Consent to contact and identify service (Babbingur Mia) via: Mobile phone ☐ Yes ☐ No SMS ☐ Yes ☐ No Voicemail ☐ Yes ☐ No		
**** Medicare No.**	**Reference No.**	**Expiry** /
Ability to speak English ☐ Very well ☐ Well ☐ Not well ☐ Not at all **Preferred language:**		
Cultural Background ☐ Aboriginal ☐ Torres Strait Islander ☐ Unknown ☐ Other:		
Additional Questions Where Applicable		
Maternal Health: How many weeks pregnant are you? What is your due date? / /		
Child Health: How many children do you have? How old are the children? / / / /		
Additional Questions: Are you currently engaged with any other services? Y N (Please Circle) If Yes which service/s.		
Safety Concerns: When workers attend your home to do a visit are there any safety concerns or Risks they may need to know about. i.e. dog?		
Next of Kin Details *(MUST be completed if client under 16 years of age)*		
Name		**Mobile**
Relationship to client		**Home**

Referred to:

☐ **Child Health**	☐ **Maternal Health**	☐ **Advocacy**	☐ **Adult Health**	☐ **Mental Health/AOD**
	☐ **Playgroup**		☐ **Men's Group**	☐ **Women's Group**

Reason for Referral:

.....

.....

Referral Form

South Coastal Babbingur Mia Team

Fax (08) 9592 5635
referrals@southcoastal.org.au

Relevant Client History:

.....

.....

.....

Referrer Details:

Referrer Name	.....	Profession	.....
Organisation	.....	Phone	.....
Referrer Name	.....	Referrer Signature	.....

Consent Details **

Please indicate who is consenting to the collection, use, and disclosure of personal health information:

☐ Adult Client ☐ Adolescent Client (16 years and over) ☐ Parent / Guardian

All information will be treated confidentially and will not be used for any other purposes than what is stated in the full consent form (signed during the first appointment). I / the client is aware that this referral is being made. I / the client understands that consent to attend the service can be withdrawn at any time.

.....	.....	.....
Client name	Client signature	Date
.....	.....	.....
Parent/ Guardian Name	Parent/ Guardian signature	Date