

WA-IHS-F-001 Indigenous Healing Service Referral Form

Please email all referrals to [IHS@MacKillop.org.au](mailto:IHS@MacKillop.org.au)

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| Client Details | | |
| Client Name: |  | |
| Cultural Background: *(Please provide details)* |  | |
| DOB: |  | |
| Gender: |  | |
| Address: |  | |
| Contact Number: |  | |
| If under 18: | **Name of Primary Carer:** |  |
| **Relationship to Child/Young Person:** |  |
| **DOB:** |  |
| **Contact Number:** |  |
| Is this child/young person under the care of the Department of Communities? | **Yes  No** *(If yes, please provide details below)* | |
| **Name of Case Manager:** |  |
| **Case Manager Contact Details:** |  |

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| Referrer Details | |
| Referrer Name: |  |
| Referrer Email: |  |
| Referrer Contact Number: |  |
| Referrer Organisation: |  |

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| Referral Details | |
| Date of Referral: |  |
| Information to inform service eligibility:  *(Check all that apply)* | Child/Young Person has experienced, or been impacted by, child sexual abuse  Child/Young Person has experienced, or been impacted by, family domestic violence  Child/Young Person has experienced, or been impacted by, been impacted by grief and loss  Child/Young Person is at risk of engaging in harmful sexual behaviour  Child/Young Person is displaying harmful sexual behaviour  Child/Young Person is displaying violent behaviour towards others  Client is a sibling, carer, or family member of a child who has been referred to the service and has been impacted by the behaviour of the child/young person  Adult who has experienced, or been impacted by, child sexual abuse  Adult who has experienced, or been impacted by, family domestic violence  Adult who has experienced, or been impacted by, grief and loss |
| Reason for Referral:  *(Please briefly outline your main reason for referring)* |  |

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| Some of the worries for this child/individual are: *(Check all that apply)* | | | |
| Feeling worried  Physical health  Not sleeping good  Not eating good  Grog, gunja or other drugs  Trouble with the law  Gets wild or aggressive  Grief and loss  Mixed up thoughts  Not going to school  Self-harm behaviour | | Suicidal behaviour or suicidal thoughts  Hearing voices or seeing things  Harmful, or worrying sexual behaviour  Feeling sad, or not interested in doing things  Trouble focusing and/or remembering things  Family trouble, humbug or worry  Running off to unsafe places  Homelessness  Diagnoses (e.g., Autism, FASD)  *Please specify:* | |
| Other concerns, or barriers to accessing service: | | | |
|  | | | |
| Things that help this child/individual feel happy and strong: | | | |
|  | | | |
| Genogram: *(Please attach a copy or insert in space below)* | | | |
|  | | | |
| Other services involved: | | | |
|  | | | |
| What are your hopes/goals for what can be achieved in counselling? | | | |
|  | | | |
| Is there contact between the child/individual and the perpetrator of abuse? | **Yes  No** *(If yes, please provide details below)* | | |
|  | | |
| Is there a current safety plan for the child/individual? | **Yes  No** *(If yes, please attach a copy)* | | |
| Does the child/individual have any allergies or special dietary requirements?  *(IHS may sometimes provide snacks)* | **Yes  No** *(If yes, please provide details below)* | | |
| Emergency Contact  *(Who can we contact if there is an emergency or if we can’t get a hold of the client and are worried for their safety?)* | **Name:** | |  |
| **Relationship to Client:** | |  |
| **Contact Number:** | |  |