

WA-F-133 Indigenous Healing Service Self-Referral Form

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

OR

Bring them by the office: 2/7 Tonkin Street, South Hedland

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| --- | --- | --- |
| Client Details | | |
| This referral is for: | Me  My child  A child in my care  Someone else | |
| My Name: |  | |
| Client Name: |  | |
| Cultural Background: *(Please provide details)* |  | |
| DOB: |  | |
| Gender: |  | |
| Address: |  | |
| Contact Number: |  | |
| If under 18: | **Name of Primary Carer:** |  |
| **Relationship to Child:** |  |
| **DOB:** |  |
| **Contact Number:** |  |
| Is this child 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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| --- | --- | --- | --- |
| Referral Details | | | |
| Date of Referral: |  | | |
| Some of the worries I have for myself/this child 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: | | | |
|  | | | |
| Things that help me/this child feel happy and strong: | | | |
|  | | | |
| What are your hopes/goals for what can be achieved in counselling? | | | |
|  | | | |
| 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 you and are worried about your safety?)* | **Name:** | |  |
| **Relationship to Client:** | |  |
| **Contact Number:** | |  |