

## COMMUNITY HEALTH SELF-REFERRAL FOR SOCIAL WORK

### Your personal details:

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Master <input type="checkbox"/> Mx <input type="checkbox"/> Other:	
* D.O.B:	Gender:
* Given name:	
* Family name:	
* Street address:	
Postcode:	
* Contact phone number: Home	Mobile
* Do you hold a current Medicare card?	<input type="checkbox"/> Yes    _ _ _ _ - _ _ _ Expiry date: _ _ / _ _ <input type="checkbox"/> No
* Do you hold a current Healthcare or Pension card?	<input type="checkbox"/> Yes    _ _ _ - _ _ _ - _ _ _ _ <input type="checkbox"/> No
Preferred medical practice:	
Preferred General Practitioner:	

Details marked with an asterisk (\*) need to be completed

**Have you spoken to your GP about your concerns?**                      **Yes / No**

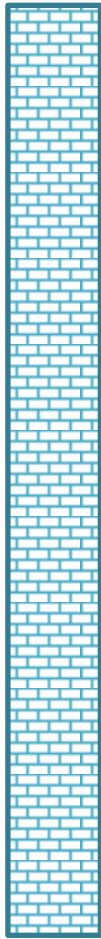
**Are you currently seeing a counsellor?**                                      **Yes / No**

**If so, who and where?**

### Please specify what type of services are needed:

<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Drug and alcohol	<input type="checkbox"/> Parenting/family issues
<input type="checkbox"/> Financial/Centrelink assistance	<input type="checkbox"/> Relationship issues
<input type="checkbox"/> Dairy/Farming assistance	<input type="checkbox"/> Youth
<input type="checkbox"/> Loss and grief	<input type="checkbox"/> Legal issues
<input type="checkbox"/> Aged Care issues (e.g. Residential care, carer stress)	<input type="checkbox"/> Housing/risk of homelessness

Please complete and sign second page



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**If you selected mental health, have you been diagnosed with a mental health condition? Please give details;**


**Please list specifically the main issues you would like support with;**


**Please list specifically what you would like to achieve through counselling;**


This form has been made for the community of Kyabram District Health Service for self-referring. Clinicians and Nursing staff will need to complete a ConnectingCare referral or complete the following SCTT tools provided on the Health.Vic website (health.vic.gov.au).

- [Consumer Information](#)
- [Referral Cover Sheet & Acknowledgement](#)
- [Summary & Referral Information](#)
- [Consent to Share Information](#)

Practitioners are encouraged to complete a detailed referral letter with client’s details.

Please sign and return this document to Kyabram District Health Service or email copy of this document completed to [referrals@kyhealth.org.au](mailto:referrals@kyhealth.org.au)

Signature		Date	
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