WELLINGTON ABORIGINAL CORPORATION HEALTH SERVICE
ICN: 792

ABN 21 471 474 869
28 Maxwell St
Wellington, NSW 2820
02 6845 5400
travisp2w@wachs.net.au

PRISON TO HEALTH
Adult Referral Form

CLIENT'S DETAILS

Name:

Date of Birth: / / Age: Sex: M

Address:

Phone: *mobile* *home* *work*

email:

Best times to contact:

Medicare Number: Reference No.: Expiry:

Client is: Aboriginal or Torres Strait Islander Neither

REFERRER'S DETAILS

Name of person completing form: Date: / /

Organisation or Service provider:

Position of person referring (if applicable):

Phone: Email:

REASONS FOR REFERRAL (must complete)

WHAT SERVICES ARE REQUIRED?

Health Education & Training Employment Legal Aid

Housing Alcohol & Other Drugs Social & Emotional Support Men's Group

ARE THERE ANY OTHER SERVICES CURRENTLY WORKING WITH THE CLIENT?

☐ No ☐ Yes – If yes, please list below

CLIENT CONSENT & RELEASE INFORMATION

Has the client consented to this referral? ☐ No ☐ Yes

Client signature: Date: / /

STAFF USE ONLY

Date referral received: / /

Referral: ☐ Internal ☐ External

Type of referral:

Team Member Allocated:

Initial contact made with client?: ☐ No ☐ Yes Date: / /