



Referral Form

Mental Health & Alcohol and Other Drug Service

SWAMS Clinic
Unit 5/55 Forrest Avenue
Bunbury 6230 WA

Phone: 08 9726 6000
Toll Free: 1800 779 000
MentalHealth@swams.com.au

About the team

The Mental Health and AOD team at SWAMS consists of tertiary qualified staff that are here to meet the needs of individuals, family and community.

Client details

Name: _____ Date of birth: ____ / ____ / _____ Age: ____

Identified sex: _____ Identify as Aboriginal or Torres Strait Islander: _____

Address: _____ State: _____ Postcode: _____

Is the client a patient of SWAMS? (please circle): YES / NO

Mobile: _____ Phone (W): _____

Is the referral of the client related to (please circle):

a) Their own mental health or substance: YES / NO b) Other's mental health or substance: YES / NO

Substances of concern: _____

Mental health of concern (please indicate symptoms or diagnosis if known and by whom):

Support requested

Counselling support: YES / NO

Social support: YES / NO

Cultural support: YES / NO

Referral details

Name: _____

Organisation: _____

Mobile: _____ Email: _____

Risks identified

Is the client currently suicidal? (please circle): YES / NO (If yes, please attach a current safety plan)

Would you consider the client safe to home visit? (please circle): YES / NO

Please list any other risks or additional information: _____

Consent

Please send completed form to MentalHealth@swams.com.au

By signing this referral, you confirm that the client has provided written or has verbally agreed to be contacted by the Mental Health and AOD team. Signed: _____ Date: ____ / ____ / _____

Please email completed referral to: MentalHealth@swams.com.au