



ASG REFERRAL FORM



Post referral forms to
Aboriginal Sobriety Group Indigenous Corporation
PO Box 7306 Hutt Street, Adelaide SA 5001
or
Email referral forms to: - ians@asg.org.au

Programs and / or Services Requested

- Substance Misuse Team- Alcohol and Other Drugs outreach support
- Rehabilitation- Leila Rankine House of Hope LRHOH (Women's)
- Rehabilitation- Lakalinjeri Tumbetin Waal LTW (Men's)

1. REFERRAL

Contact date:/...../.....

Has the person given consent for this referral: Yes No

Client Type Self-referral External referral

2. REFERRED PERSONS DETAILS

Given Names Surname

DOB...../...../..... Age.....

Address Suburb

P/C.....

Phone..... Mobile.....

Other.....

Aboriginal/Torres Strait Island YES NO Male/Female (circle)

Interpreter required YES NO

3. REFERRING PERSON / AGENCY

Referred by.....

Position.....

Agency.....

Phone.....

..... Mobile.....

Email.....

How did the referring person learn about Aboriginal Sobriety Group Indigenous Corporation?

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.....

Best time to contact client Weekdays Morning Afternoon

Best way to be contacted Mobile SMS Landline

Email.....

4. PRESENTING ISSUES/ SUPPORT REQUESTED

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5. LEGAL ISSUES: (PLEASE GIVE DETAILS)

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6. LAWYERS NAME AND CONTACT DETAILS

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7. ANY HISTORY OF VIOLENT BEHAVIOUR TOWARDS FAMILY, WORKERS OR THE WIDER COMMUNITY

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8. IS THE PERSON HOMELESS: (PLEASE GIVE DETAILS)

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9. DIAGNOSED MEDICAL ISSUES: (PLEASE GIVE DETAILS)

PHYSICAL

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EMOTIONAL/ MENTAL HEALTH

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ANY RISK OF SELF HARM/SUICIDE

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10.DETAILS OF ANY PRESCRIBED MEDICATIONS CURRENTLY USED:

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11.NAME OF REGULAR GP AND CONTACT DETAILS

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12.DETAILS OF SUBSTANCE MISUSE

DRUG OF CONCERN	AVERAGE DAILY USE	ROUTE	LAST USED

Please attach copies of any relevant documents to the referral:

- Parole Conditions
- Bail Conditions
- Corrections Conditions
- Details of Upcoming Court Dates
- Hospital Discharge Summaries (if client still in hospital then include treating Doctor Report)
- Current Medication Scripts
- Mental Health Ward Discharge Summaries (if client still in hospital then include treating Doctor Report)
- Psychiatrist Reports
- Treating Doctor Reports
- Depot Schedule
- Community Treatment Orders
- Public & Community Housing Application Details, Organisation details, Category Status, etc.
- Copies of ID: Medicare Card, Centrelink Card, Drivers Licence, Birth Certificate etc.

Please Note:
Referred person is not eligible to enter the Residential Rehabilitation Programs if the following:-

- Home Detention Bail

- Unstable Complex Mental Health Conditions
- Clients on Methadone or Suboxone Programs
- Clients With Pending Sexual Offence Charges Against Children, Violent Offences Against Children, Sexual Offense Convictions Against Children, Violent Sexual Offence Convictions Against Children
- *Clients who are on medications for physical or mental health, **will not be accepted at** unless they come with at least 2 weeks' worth of medications, Webster Packs are preferred if there are more than 2 regular medications, and current scripts for all the medication.*

Please Note:

Referred Person may not be eligible for Residential Rehabilitation Programs if the following:-

- History of Non-compliance to medications, changes in medications, new medications
- Pending/current violent sexual charges, pending/current sexual charges, past violent sexual convictions, past sexual convictions

**ABORIGINAL SOBRIETY GROUP INDIGENOUS CORPORATION
STAFF USE ONLY**

(Office Use) Referral Taken By:	Referral Allocated To:
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182-190 Wakefield Street, Adelaide SA 5000

PO Box 7306, Hutt Street, Adelaide

Phone: (08) 8223 4204

Fax: (08) 8232 6685

Email: ians@asg.org.au

Website: www.asg.org.au



Client Release of Information

I, (Name)

Hereby give the Aboriginal Sobriety Group Indigenous Corporation permission to disclose and or discuss any concerns regarding my case history with relevant organisations.

I understand that this information will only be used to prepare and co-ordinate a treatment case plan.

The contents of this authorisation have been explained to me and I understand the nature of the information that will be received and released about me. I also understand that this consent form can be altered or changed at any time during the course of treatment.

Individual or Agency and Phone Number	Date	Initials

Clients Signature: _____ Date:

Witness Name: _____ Date:

Witness Signature: _____ Date: