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

- ☐ **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……………………………………………

Agency……………………………………..............................

Phone………………………………………………………………………………………

……………………………… Mobile……………………………………………..

Email……………………………………..

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

…………………………………………………………………………………………………

…………………………………………………………………………………………………

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 MEDCATIONS 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

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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:

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: