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|  | **REFERRAL FORM** |

Alcohol and Other Drugs Outreach Support

LTW Men’s Rehabilitation Centre

LRHOH Women’s Rehabilitation Centre

Alcohol and Other Drug Counselling (Riverland only)   
 Aboriginal Mental Health (Riverland only)

**------------------------------ Email referral form to:** [**referrals@asg.org.au**](mailto:referrals@asg.org.au) **----------------------------**

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| **REFERRAL** | | | | |
| Date: | Referral Type: | Self-Referral | Community | External Agency |

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| **REFERRED PERSONS DETAILS** | | | | | | | |
| Given Names: | | Surname: | | | | | |
| DOB: | | Age: | | | | | |
| Aboriginal/Torres Strait Islander:  Yes  No  Language group: | | Interpreter Required:  Yes  No | | | | | |
| Address: | | | | | | | |
| Suburb: | | | | Postcode: | | | |
| Phone: | | Email: | | | | | |
| Has the person given consent for this referral (select box) | | | Yes | | | No | |
| Best time to contact client (select box) | Weekdays | | Morning | | | Afternoon | |
| Best way to be contacted (select box) | Mobile | | SMS | | Landline | | Email |

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| **REFERRING PERSON / AGENCY** | | |
| Referral By: |  | |
| Position: |  | |
| Agency: |  | |
| Phone: |  | Mobile: |
| Email: |  | |
| How did the referring person learn about Aboriginal sobriety group? | | |

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| **Has the client ever been charged with or convicted of sexual offences against an adult or child?** |
| ☐ No ☐ Yes (If yes, client will not be eligible for our program) |

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| **MANDATORY REQUIREMENTS** |
| **Please attach the following information**   * Medicare Card * Centrelink Card * Basics card * Drivers Licence * Birth Certificate or Passport * Client consented to 7 Day detox prior to entering rehabilitation   (Please be aware DASSA Detox operates under a smoke free policy) |

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| **PRESENTING ISSUES / SUPPORT REQUESTED** |
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| **DETAILS OF SUBSTANCE MISUSE** | | | |
| DRUG OF CONCERN | AVERAGE DAILY USE | ROUTE | DATE LAST USED |
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| **DIAGNOSED MEDICAL ISSUES  NO  YES (PROVIDE DETAILS)** |
| PHYSICAL |
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| EMOTIONAL/ MENTAL HEALTH (Please provide details of last episode or admission if applicable) |
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| **ANY RISK OF SELF HARM/SUICIDE (Please provide details of last episode or admission if applicable)** |
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| **HISTORY OF VIOLENT BEHAVIOUR  NO  YES (PROVIDE DETAILS)** |
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| **DETAILS OF ANY PRESCRIBED MEDICATIONS CURRENTLY USED** | | |
| PRESCRIBED MEDICATION | DAILY INTAKE | COMMENTS/ INSTRUCTIONS |
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| **NAME OF REGULAR GP AND CONTACT DETAILS** |
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| **LEGAL ISSUES:  NO  YES (PROVIDE DETAILS)** |
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| **LAWYERS NAME AND CONTACT DETAILS** |
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| **IS THE PERSON HOMELESS  NO  YES (PROVIDE DETAILS)** |
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| **PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION (ATTACH PAGES IF REQUIRED)** |
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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 Summary (if client still in hospital - include treating doctor report)
* Psychiatrist Reports
* Treating Doctor Reports
* Depot Schedule
* Community Treatment Orders
* Public & Community Housing Application Details, Organisation details, Category Status, etc.

**-------------------------------------------------------- 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

Referred person **is not** eligible to enter the Residential Rehabilitation Programs if the following:

* Home Detention Bail
* 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

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|  | **CLIENT RELEASE OF INFORMATION** |

I, ………………………………………………………, hereby give the Aboriginal Sobriety Group Indigenous Corporation permission to disclose and/or discuss any information about myself with relevant organisations.

I understand that this information will assist workers in meeting my needs as a client and coordinating appropriate services in order to maximise outcomes.

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, at my request, this consent form can be altered or changed at any time.

Please put a line through any services/organisations that you do not want staff discussing your information with.

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| Aboriginal Legal Rights Movement (ALRM / PCP) | Adelaide Day Centre |
| Aboriginal Family Support Services (AFSS) | Aboriginal Hostels Limited |
| Uniting Communities | ANCOR |
| Sonder Care / Closing the Gap | KWY |
| Alcohol and Drug Information Service (ADIS) | Centrelink / MyGov |
| Relationships Australia (RASA) | Watto Purrunna |
| Drug and Alcohol Services of SA (DASSA) | Public Trustee |
| Department of Correctional Services | Disability SA |
| Medical Centre: | Hutt Street Centre |
| General Practitioner: | Life Without Barriers |
| Solicitor: | Nunkuwarrin Yunti |
| Courts Administration Authority | SA Health |
| Nunga Mi:Minar / Ninko Kurtangga Patpangga | SAPOL |
| Moorundi Aboriginal Community Controlled Health Service | Life Without Barriers |
| South Australian Housing Authority | Brian Burdekin Clinic |
| Community Housing Organisations;   |  |  |  |  | | --- | --- | --- | --- | | * Anglicare SA | * Portway Housing | * Uniting SA | * Westside Housing | | * Unity Housing | * Women’s Junction | * Cornerstone | * Baptist Care | | * Salvation Army | * Housing Choices | * IRIS | * IHEP/OARS | | |
| Other: (Please Specify) | |

Client Signature:…………………………………………………………………………………………………. Date:……………………….

Witness Name & Signature:……………………………………………………………………….……….. Date:..........................