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|  | **REFERRAL FORM - ALL PROGRMS** |

[ ]  Alcohol and Other Drugs Outreach Support

[ ]  LTW Men’s Rehabilitation Centre

[ ]  LRHOH Women’s Rehabilitation Centre

[ ]  AOD Prison Counselling

[ ]  Alcohol & Other Drugs/Social & Emotional Wellbeing (Riverland only)

[ ]  Youth Alcohol and Other Drug Work (Riverland only)
[ ]  Aboriginal Mental Health (Riverland only)

**------------------------------ Email referral form to:** **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 [ ]  NoLanguage 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 |
|  |
| 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)** |
|  |

**Please attach copies of any relevant documents to the referral:**

* Parole Conditions
* Precis (Precis of information and reports received from magistrates, agents, prisoners, etc.)
* 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 will 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
* 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.

|  |  |
| --- | --- |
| [ ]  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;

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| * 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:..........................