



## External Referral Form

### Riverland Social & Emotional Wellbeing Program

SUBSTANCE MISUSE/ MENTAL HEALTH/ SEWB

#### REFERRAL

Contact Date:

Has the person given consent for this referral

Yes:

No:

Client type

Self-referral:

External Referral:

#### REFERRED PERSONS DETAILS

Given Names:

Surname:

DOB:

Age:

Address:

Postcode:

Phone:

Mobile:

Aboriginal/TSI:

Male/ Female:

#### REFERRING PERSON/AGENCY

Referred by:

Agency:

Phone:

Mobile:

#### HOW DID REFERRING PERSON LEARN ABOUT THE SEWB PROGRAM?

Best time to contact client

Weekday:

Morning:

Afternoon:

Best way to contact

Mobile

SMS

Landline

Email

#### PRESENTING ISSUES/ SUPPORT REQUESTED FROM ABORIGINAL SOBRIETY GROUP INC:

#### LEGAL ISSUES: (PLEASE GIVE DETAILS)

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

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**IS THE PERSON HOMELESS: (PLEASE GIVE DETAILS)**

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**DIAGNOSED MEDICAL ISSUES: (PLEASE GIVE DETAILS)**

PHYSICAL HEALTH

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EMOTIONAL/ MENTAL HEALTH

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ANY RISK OF SELF HARM/SUICIDE

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**DETAILS OF ANY PRESCRIBED MEDICATIONS CURRENTLY USED:**

Prescribed Medication	Daily Intake	Comments/ Instructions

**NAME OF REGULAR GP AND CONTACT DETAILS**

GP Clinic:	GP Name:
Address:	
Contact Number:	

**DETAILS OF SUBSTANCE MISUSE**

DRUG OF CONCERN	AVERAGE DAILY USE	ROUTE	LAST USED

**ABORIGINAL SOBRIETY GROUP INC STAFF USE ONLY**

<b>(Office Use) Referral Taken By:</b>	
<b>Referral Allocated to:</b>	



## 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: