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|  | **REFERRAL FORM** |

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| **Referral** | | | | |
| Date: | Referral Type: | Self-Referral | Internal | External |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |
| Are you registered with NDIS? | 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: |  | |

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| **Support Requested/ Presenting Issues** |
| Is the client considering detox or rehabilitation?  Yes  No |

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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 programs) |

I, ………………………………………………………, hereby give the Aboriginal Sobriety Group Indigenous Corporation permission to disclose and/or discuss any information about myself with relevant organisations. **Please note that we are required to report information pertaining to safety, welfare and wellbeing.**

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

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