**REFERRAL FORM**

**Client Details:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aboriginal / Torres Strait Islander Yes / No

Receiving Centrelink Yes / No

I understand that if I have provided false or misleading information as part of my referral or during my assessment appointment I will be subject to immediate dismissal from the rehabilitation programme.

**Client Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Agency / Family members/ GRSI staff (for self referred):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby confirm that I have provided all the necessary and required information to support client’s application to rehabilitation service and that are true and correct to the best of my knowledge as of this date.

**Referrer Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency /Next of Kin contact person:

Emergency / Next of Kin contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment History**

1. Has client been to rehabilitation previously? Yes / No

If Yes, please provide details including year of treatment, treatment provider and length of sobriety before relapse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Top of Form**

**Drug History**

|  |  |  |
| --- | --- | --- |
| **Substance** | **Age started** | **How often** |
| Alcohol |  |  |
| Methamphetamine |  |  |
| Cannabis / Synthetic Cannabis |  |  |
| Heroin |  |  |
| Ecstasy |  |  |
| Tobacco |  |  |
| Prescription Drugs (Tramadol, pain killers, seroquel) |  |  |
| Benzodiazepines (valium) |  |  |
| Volatile Solvents (sniffing) |  |  |
|  |  |  |
|  |  |  |

**Medical History**General Medical History – including any diagnoses and treatment plans:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any history of seizures or epilepsy? Yes / No Date of last episode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has client recently been hospitalized? Yes / No

If Yes, please provide details including date of admission and what for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health**

Does the client have a history of involvement with mental health services? Yes / No

Is the client currently receiving mental health treatment? ? Yes / No

Symptoms (please tick): Severe Depression □ Severe Anxiety □ Bi Polar □ PTSD □ Psychotic Disorder□ Eating disorder □ Personality Disorder □ ABI □ Intellectual Disability □

Please provide details regarding diagnosis, symptoms, insight, hospitalisation and treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medical, health and welfare professionals involved in the client’s care**:

|  |  |
| --- | --- |
| **Service Provider/Contact Details** | **Recommendation** |
|  |  |
|  |  |
|  |  |
|  |  |

**Risk Issues:** Please comment on history of ideation/behaviour to harm self or others

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History: (Mandatory)**

Please list down client criminal history of a violent nature such as **sexual assault, aggression to staff** and outcome of court.

|  |  |
| --- | --- |
| **Criminal/ Violence History** | **Court outcome** |
| **1.** |  |
| **2.** |  |
| **3.** |  |

**INFORMATION FOR REFERRING AGENCY / PRACTITIONER**

To be considered eligible for the service, potential residents must meet all of the following criteria:

**Eligibility Criteria:**

* Male or Female and over the age of 18 years old (No couples allowed)
* Potential residents may be required to undergo detoxification. The service reserves the right to request a medical clearance and/or urine sample to ensure potential residents is substance free.
* For Mental health co-morbidity potential residents, the predominant presenting issue is alcohol and other drugs and Community Mental Health are linked to support the client
* Potential resident is actively engaged with counselling and/or support services OR agrees to engage with an appropriate agency or service as soon as possible.
* Committed to abstinence for duration of program

**Exclusions:**

* Acute mental health clients that are deemed unstable and that have the potential to place themselves and others at risk are not eligible to enter the service
* Potential residents who have identified behavioural or legal issues that have the potential to impact on their stability or safety of others as a resident and capacity to engage effectively within GRSI programme timetable are not eligible to enter the service.

**2) Consent to Release Information**

The referring service or agency must provide a signed consent for release of information prior to the assessment being agreed upon.

**3) Appointment for Eligibility Assessment**

The referring agency or self-referred client can send an email to [admin@grsi,org.au](mailto:admin@grsi,org.au) or fax to 08 9021 4731 the referral form.

If you wish to speak to staff, you may contact GRSI office @ 9021 4732

Referring agencies and/or client will be contacted within 24 hours to arrange an appointment to complete an assessment.

This process will further assess the eligibility of the client to the service and identify further assistance they may require.

**CHECK LIST:**

The client meets the eligibility criteria

A signed Consent for Release of Information is attached

An appointment been made for Eligibility Assessment

Detoxification and/or medical report submitted

Medicare and Centrelink number

Appointment time: Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Further Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_