REFERRAL FORM

Please send form to the Central Intake team E: intake@drugarm.com.au

Referral From	
Organisation Name:	
Program Name:	
Worker Name:	
Address:	**Phone:**
	Fax:
	Email:
Worker Signature:	**Date:**
Has the client consented to this referral? ☐ Yes ☐ No	
Does the client consent to you being updated on the progress of this referral? ☐ Yes ☐ No	
Details of individual being referred	
Name:	
Date of birth:	**Gender:** ☐ Male ☐ Female ☐ Other
Age Group: ☐ 16-17 ☐ 18–25 ☐ 26–40 ☐ 41–60 ☐ 61+	
Address:	**Home Phone:**
	Mobile:
	Other:
Parent / Carer / Guardian Name (If appropriate):	
Principal drug of concern (If appropriate):	
Reason for referral	
Client Case Summary / Treatment History / Issues Identified	

Referral Follow Up **OFFICE USE ONLY**	
Contact made with: ☐ Individual Referred ☐ Service Referred To	
Contact method: ☐ In Person ☐ Phone ☐ Other________________________________	
Date completed:	**Time completed:**
Worker name:	**Worker signature:**
Notes **OFFICE USE ONLY**	