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

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| **Referral From** |
| **Organisation Name:** |
| **Program Name:** |
| **Worker Name:** |
| **Address:** | **Phone:** |
| **Fax:** |
| **Email:** |
| **Worker Signature:** | **Date:** |
| **Has the client consented to this referral?** [ ]  Yes [ ]  No**Note: The outcome of this referral will not be provided without the client’s consent.** |
| **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** |
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