Please send form to the Central Intake team E: [intake@drugarm.com.au](mailto: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** | | | | |
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|  | | | | |
| **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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