C O N F I D E N T I A L - REFERRAL FORM

(Please email referrals to: WCADS@holyoake.org.au)

Referrer's details

(If self-referred, please skip this section and proceed to Client Details)

Referring Person		**DOJ No:** (if applicable)	
Organisation		**Date of Referral**	
Contact Details		**Fax No.**	
E-mail Address		**After Hours**	**Yes / No**

Client details

Name		**Aboriginal / TSI** (Please Circle)				**Yes / No**	
Date of Birth		**If Aboriginal would you prefer an Aboriginal Counsellor (Please Circle)**				**Yes**	
Country of Birth		**Male**		**Female**		**Other**	
Residential Address							
Postal Address							
E-mail Address							
Mobile No:		**Home / Work No.**					
Has current Driver's Licence?		**Own transport?**					

Client Type (Circle)	**Own Drug Use**	**Other's Drug Use**	**Both Own & Others**	**Non AOD Issue**

Preferred engagement (Pls circle multiple modalities if applicable)	**Face-to-face Counselling**	**Video Counselling**	**Telephone Counselling**

Current Substance Use

SUBSTANCE	Yes (Tick)	Frequency Of Use	Quantity (Each Use)	Duration Of Use (Months)	Additional Information
Alcohol					
Cannabis					
Amphetamines					
Heroin					

Other Opiates					
Hallucinogens					
Party Drugs (XTC, GHB)					
Cocaine					
Prescription Medication					

Mental Health	Yes	No	Unsure	Comments
Suicidal Thoughts				
Suicidal Behaviour				
Self-Harm Behaviour				
Aggressive Behaviour				
Anxiety				
Depression				
Mood Disturbance				
Delusions				
Paranoia				
Hallucinations				
Other				
Known Mental Health Treatment/History				

Physical Health	Yes	No	Unsure	Comments
Current Issues				
History				
Medications				
Pregnancy / Breastfeeding				
Seizure History				

Accommodation	Yes	No	Unsure	Comments
Stable/Safe Housing				
Relationships	**Yes**	**No**	**Unsure**	**Comments**
Domestic Violence				
Children / Dependants				
Parenting Concerns				
DCP Involvement				

Legal Issues	Yes	No	Unsure	Comments
Current Police Charges				
Prior Convictions				
Court Involvement				
DOCS Involvement				
Family / Other				

Financial	Yes	No	Unsure	Comments
Employed				
Centrelink				
Financial Hardship				
Unmanageable Debt				

Social Support	Yes	No	Unsure	Comments
Family				
Pro-Social Friends				

COUNSELLING AND SUPPORT
LIFE CHANGING

HOLYOAKE
FAMILY • INDIVIDUALS • YOUTH

Reasons for Referral

Other Agencies Involved

Release of Information Clause

Client to Contact WCADS For Appt?	**Yes**	**No**	**Referrer to Contact WCADS For Appt?**	**Yes**	**No**
Parents to Be Involved (If Applicable)	**Yes**	**No**	**Authorisation for WCADS To Contact Client**	**Yes**	**No**
If relevant, I give consent for Holyoake to receive a copy of RAMP / Discharge Plan / TRIAGE.				**Yes**	**No**

Please sign below if you give consent for Holyoake to create a confidential record on our secure Data Management System.

Client Signature: _____ **Date:** _____

Parent Signature:
(if client under 18yo) _____ **Date:** _____