**FM: Referral to Holyoake Individual & Family Services**

**Contact Details**

Phone: 9416 4444

Fax: 9416 4443

[Clientservices@holyoake.org.au](mailto:Clientservices@holyoake.org.au)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer’s Details** | | | | | | | | | | | | |
| Referring Person |  | | | | | | | Job Title | |  | | |
| Organisation |  | | | | | | | | | | | |
| Contact Details | E-mail |  | | | | | | Phone | |  | | |
| Date of Referral |  | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | |
| First Name |  | | | | | Last Name | | |  | | | |
| Date of Birth |  | | | | Age | | | | Circle  Female Male Other | | | |
| Residential Address |  | | | | | | | | | | | |
| Telephone Numbers | Mobile | | | | | | Home | | | | Work | |
| Country of Birth |  | | | Circle  Aboriginal TSI CALD | | | | | | Interpreter Required | | Circle  Yes No |
| Own Use | Circle  Yes No | | Other’s Use | | | | Circle  Yes No | | | Relation to User | | |

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| --- | --- | --- | --- | --- | --- |
| **Substance Use** | | | | | |
| **Substance** | **Tick** | **Amount Used** | **Frequency Of use** | **Duration of Use** | **Additional Information** |
| Alcohol |  |  |  |  |  |
| Cannabis |  |  |  |  |  |
| Methamphetamines |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Other Opiates |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Identified Risks in Working with the Client** | | | | | | | | |
| History of Aggression/Violence | | Yes | No | Currently Pregnant | | | Yes | No |
| History of Self-harm/Suicidality | | Yes | No | Positive for BBV | | | Yes | No |
| History of Unsafe Injecting Practice | | Yes | No | Currently Lives Alone | | | Yes | No |
| Restraining Order | | Yes | No |  | | |  |  |
|  | | | | | | | | |
| **Current Medical/Mental Health Problem(s) and Prescribed Medication(s)** | | | | | | | | |
|  | | | | | | | | |
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|  | | | | | | | | |
| **Other Agencies Involved (please complete and attach completed release of information)** | | | | | | | | |
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| **Reason For Referral** | | | | | | | | |
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| **Authority to Release and Obtain Information** | | | | | | | | |
| I [please print full name], …………………………………………………………………………………………….. of ……………………………………………………………………………………………………………..………….  [please print current address]  hereby consent to Holyoake releasing and obtaining reports and information as specified below: | | | | | | | | |
| Person | Agency |  |  |  | Address | Information | |  |
| …………………………. | …………………………. | | | | ……………………….… | ………….………… | | |
| …………………………. | …………………………. | | | | ……………………….… | ………….………… | | |
| SIGNATURE:..………………..……………………………………………………………………………….. WITNESS: ………………..………………………………………………………………………………....... Please Print Full Name of Witness: ……..…………………………………………………………………  DATE: .……/..……/ ..…… | | | | | | | | |