



Drug & Alcohol Treatment Service Client Referral Form

Personal Details			
Name		Date of Birth	
Address		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Phone		Mobile	
Email		Country of Birth	
Indigenous Status	Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Aboriginal but not Torres Strait Islander <input type="checkbox"/> Torres Strait Islander but not Aboriginal <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Not Stated <input type="checkbox"/>		
Preferred Language		Translator Required?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emergency Contact			
Name		Relationship to Person	
Address		Phone	
Reason for Referral / Presenting Issues and/or Risks	Own Drug Use <input type="checkbox"/> Other's Drug Use <input type="checkbox"/>		
Principal Drug of Concern			
Other drugs of concern (you may tick more than one box)			
Alcohol	<input type="checkbox"/>	Amphetamines	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	Benzodiazepines	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>
MDMA (Ecstasy)	<input type="checkbox"/>	Heroin	<input type="checkbox"/>
LSD	<input type="checkbox"/>	Methadone	<input type="checkbox"/>
Morphine	<input type="checkbox"/>	Nicotine	<input type="checkbox"/>
Volatile Solvents	<input type="checkbox"/>	Opioid analgesics not further defined	<input type="checkbox"/>
Psychostimulants not further defined	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>
Person Making Referral			
Name		Date of Referral	
Organisation		Phone	
Fax		Email	
Signature			