Aboriginal Alcohol and Drug Service
Healing Aboriginal Peoples: Mind, Body and Spirit

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REFERRAL FORM

Please complete and return via email on referral@aads.org.au or fax number 08 92211585

Referral Date: __/__/____ Self Referral ❒Yes ❒ No

Referring Agency:_____ Phone:(__)_____

Contact Person: _____ Email:_____ Fax:(__)_____

Address_____

Has referral to AADS been discussed with client? ❒Yes ❒ No

If no please explain: _____

_____

If yes, permission has been provided by client for AADS to make contact? ❒ Yes ❒ No

Client details:

Name:_____ Date of Birth: __/__/____ Age_____

Gender ❒M ❒ F Aboriginal/Torres Strait Islander ❒ Other ❒_____

Address:_____

Phone:(__) _____ Mobile:_____ Contact:(__) _____

Permission to leave a voice and / or send a text message: ❒Yes ❒ No

Reason for referral:_____

_____

_____

SUBSTANCE USE:

Type of Substance used	Amount used	Frequency	Duration	Date last used
Alcohol				
Amphetamine				
Benzodiazepines				
Cannabis				
Ecstasy /Party drug				
Opiates/ Heroin				
Hallucinogens / LSD				
Solvents / Inhalants				`
Other				

Has client recently presented to hospital due to substance related issue: ❒Yes ❒No
If yes please provide details:_____

_____

If yes, client consents to AADS requesting hospital discharge summary: ❒Yes ❒No

Identified Risks:

❒ Self-harm / suicide ideation	❒ Aggression / Violence
❒ Drug overdose	❒ History of unsafe injecting practice
❒ STI / Blood Borne Virus (BBV)	❒ Pregnancy
❒ Harm from others	❒ Homeless
❒ Other	

If risk is identified, please provide more information:

_____
_____
_____
_____

Current / Previous Mental Health issues:

_____
_____

Current / Previous Medical issues:

_____
_____

Other known services providing care:

Service	Contact person	Contact number	Permission to contact
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No

Legal issues: _____
_____

Please circle the Treatment Options that the client is requesting:

Individual Alcohol and Drug Counselling	Drug and Alcohol Family support counselling	
Brief intervention	Harm reduction	Reduce use
Pharmacotherapy referral	Withdrawal referral	Residential referral
Advocacy / Support	Unsure client wants to discuss options	

Is client able to attend East Perth for appointments? ❒ Yes ❒ No

Referrer Signature: _____ **Client Signature:** _____

(AADS staff only)
Appointment details
Client Contacted: ❒ Yes ❒ No Appointment date:__/__/____ Time: __:__hrs
Allocated to: ❒ AOD Support ❒ Outreach Referrer notified of outcome: ❒ Yes ❒ No
❒ Declined services:_____
❒ External Referral to: _____
❒ Declined Referral: _____