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|  | **CDAS referral form** |

**Please email this form to: CDAS@centacare.org.au**

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| **Referral Date:** |  | | |
| Referring Agency: |  | Name Referring Person: |  |
| How did you find out about CDAS? |  | Contact Details: |  |

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| **Client Information** | | | | |
| Given Names |  | | | |
| Surname |  | | | |
| Date of Birth | \_\_\_\_/\_\_\_\_ /\_\_\_\_ | Age: | | Gender: |
| Address | Post code | | | |
| Contact Details: | Phone: | | Mobile: | |
| Can we leave a message on these numbers? 🗆Yes 🗆No | | | |
| Household Living Arrangements (e.g. lives alone, with others, partner, children, parents) |  | | | |
| Who is Seeking Assistance? | 🗆 Young Person (10 – 30 years of age)  🗆 Family & Young person  🗆 Family (Parent, sibling, partner)  🗆 LGBTIQ (10 years and over)  🗆 ATSI young person (10 – 30 years of age)  🗆 CALD (10 – 30 years of age) – if yes, is an interpreter required? 🗆 Yes 🗆 No | | | |
| If family/friend(s) support is requested by client who is the contact Person? | Name contact person: | | | |
| Relationship to the client: | | | |
| Contact Number: | | | |

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| **Reason for referral** (e.g. AOD issues including drug of choice, frequency of use, relationship issues, court ordered) |
| **Is the client interested in:**  🗆 AOD Counselling 🗆In home detox 🗆In home detox and AOD Counselling  🗆 Connecting with the AOD Lived Experience Worker 🗆 Connecting with the LGBTIQ Peer Worker |

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| **Other Issues/Supports involved** (e.g. mental health,legal, physical) |
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**Client consent**

The purpose of this consent has been explained to me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I give permission to have my personal information shared with ***CDAS*** for the purposes of referral. I understand that once received, ***CDAS*** will contact me and also confirm with the referrer the outcome of this follow up. This consent for sharing of information will expire within one month of the referral being received. I understand that sharing my information with ***CDAS*** is done with the aim of ensuring I receive the best possible service.

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| **Client Name** |  | | |
| **Signature** |  | **Date of consent** |  |
| **Name of Guardian/Carer**  (where applicable) |  | | |
| **Signature** |  | **Date of consent** |  |

**\*Verbal consent should only be used where it is not practicable to obtain written consent.**

*I have discussed how and why certain information about the client may need to be provided to or discussed with other service providers or nominated persons. I am satisfied the client understands the proposed uses and disclosures, and that the client has provided their informed consent for this to occur.*

**Reason written consent was not possible:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Name of referrer** |  | **Signature** |  |
| **Position** |  | **Date** |  |

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| ***Office Use Only*** | |
| Name of worker receiving referral |  |