**Date Referral Made:**

**Client Details**

|  |  |  |
| --- | --- | --- |
| Given Name(s): | Family Name: | |
| Address: | Phone: | |
|  | Date of Birth: | Age: |
| Gender:  Male  Female  Other: | | |
| Cultural Identity: € Aboriginal € Torres Strait Islander € Both € CALD: | | |
| Emergency Contact Name: Phone: | | |

**Referrer Details**

|  |  |
| --- | --- |
| Worker Name: | Position Title: |
| Email: | Agency Name: |
| Phone Number: | Fax: |
| Address: | |
| How long have you or your agency worked with the client? | |
| Has the client read and signed the CNAPDA Consent and Authority Form?  Yes  No | |

**Relevant Referral Information**

|  |  |  |
| --- | --- | --- |
| **Presenting issues** | | |
| Drug and Alcohol  Mental Health Concerns  Domestic Violence  General Health Concerns  Disability | Legal issues  Social Isolation  Unemployment  Cultural Issues | Homelessness/Housing risk  Family/Custody issues  Financial Hardship  Grief and Loss |
| **Reasons for referral to CNAPDA**  Detail presenting concerns and background information that has prompted referral | | |
|  | | |
| **Interventions to date**  What has been tried and what has or hasn’t been successful, provide reasons. | | |
|  | | |
| **Evidence of unmet needs/service gaps**  Provide detail of how the current service system has been unable to meet the client’s needs. | | |
|  | | |
| **Purpose of CNAPDA referral**  What does the client hope to achieve from this referral? What specific supports are being sought from CNAPDA? | | |
|  | | |
| **Are there any barriers preventing the client from accessing services?** | | |
|  | | |
| **Please provide details of the client’s strengths**  These can be drawn from any context and can include personal qualities, supportive family members or communities and referrer’s own observations | | |
|  | | |
| **Is there any other information that you feel would be useful for the Panel to know**? | | |
|  | | |

**Additional Information** (please provide more detail in any relevant areas below)

|  |  |
| --- | --- |
| Please select the most relevant description for each domain based on your knowledge of the client | |
| **DOMAIN** | **ASSESSMENT, RATING AND COMMENT** |
| **Drug & Alcohol Use** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Substances of Concern  (principle first) | Length of Use  (No. of months years) | Amount of Use  (gram, point etc) | Frequency of Use  (Daily, weekly, etc) | Method of Use  (smoke, inject etc) | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   Please fill in table to the best of your knowledge:  If injecting, has the client had a **BBV** screen recently? (HCV, HBV, HIV)  Yes  No  If Yes:  3 months ago or less  More than 3 months but less than 12 months  More than 12 months  **Comment** (include knowledge of harm reduction strategies etc.):  Please rate the client’s **level of motivation** with respect to making changes to their drug/alcohol use:  Pre-contemplative  Contemplative  Planning  Action  Maintenance  **Comment:** |
| **Mental Health & Well Being** | Please provide more detail: |
| **Relationship with Others** | Please provide more detail: |
| **Physical Health & Well-Being** | Please provide more detail: |
| **Living**  **Situation** | Please provide more detail: |
| **Cultural Considerations** | Please provide more detail: |
| **Safety and Legal Issues** | Please provide more detail: |
| **Family Support** | Please provide more detail: |
| **Disability** | Please provide more detail: |
| **Education and Employment** | Please provide more detail: |

**Other current services/workers involved**

|  |  |  |
| --- | --- | --- |
| **Agency:** | **Worker/s:** | **Support provided:** |
|  | | |
| **Agency:** | **Worker/s:** | **Support provided** |
|  | | |
| **Agency:** | **Worker/s:** | **Support provided** |
|  | | |

**Please attach any relevant medical and allied health information**

Include any info on diagnoses, hospitalisations, medications etc.