**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.