

Referral Form

Phone: (08) 9388 5000
Fax: (08) 9380 9793
Web: www.sjog.org.au/dawn e-mail: dawn@sjog.org.au

The Drug and Alcohol Withdrawal Network (DAWN) provide a Clinical Nurse Specialist to support your client in a planned home based withdrawal treatment for people choosing to safely reduce or cease their substance use, or a low medial inpatient detox at the Serenity Withdrawal Unit. Aboriginal and Torres Strait Islander consumers may also benefit by accessing DAWN's Aboriginal Health and Cultural Worker.

If you have any questions about whether your client is suitable for the DAWN service, please do not hesitate to speak with your locality DAWN CNS (if avail) or the DAWN triage CNS on 9388 5000.

Reason for referral: Home based Withdrawal Serenity Withdrawal Unit

Consumer Information:

Name: _____	DOB: _____	Gender _____
Address: _____	Drug Free Environment: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Contact number: _____	Able to leave message: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Preferred Language: _____	ATSI: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Able to take time off work/school as required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Support Person: _____	Contact number: _____	
Nominated GP: _____	Contact number: _____	

Referrer details:

Name: _____	Phone: _____
Fax: _____	email _____
Organisation: _____	Job Title: _____
Follow up plan _____	
Next Appointment: _____	
Any other agencies involved _____	

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NB: If you are an AOD or MH service, a copy of the client assessment is required in lieu of this page

*** NB: PLEASE ATTACH ANY RELEVANT RISK ASSESSMENTS ***

Substances: type; amount used and method of use:

- Primary Drug
- Other Drug use
- Current medications

To provide a safe withdrawal, eligibility criteria will be assessed on the following information:

Withdrawal history: (attempts/complications/seizures etc.)

General medical history: (diagnosis/hypertension/operations/hospital admissions/allergies /Pregnancy etc.)

Mental Health (diagnosis/treatment/admissions/suicide attempts or thoughts/self-harm):

Risk to/from others (violence/outstanding drug debt/VRO/problematic behaviour):

Legal (diversion client/forensic history/current charges/curfews/VRO's):

Any other relevant information:

I am happy for my information to be shared with DAWN via email, telephone or facsimile.

Referrer's signature _____

Consumer's signature _____

Date: _____

Date: _____