South West Community Alcohol and Drug Service (SWCADS)	ST JOHN OF GOD Social Outreach	Affix Client Label Here

Referrer Details
Contact Person:_____ Agency:_____
Phone:_____Fax:_____Mobile:_____
Email:_____ Date: / /
Client Details
Name:_____ DOB: / / Age:_____ Gender: M □ F □ O □
Address:_____ Postcode:_____
Contact Tel:_____Email:_____
Aboriginal/TSI: Yes □ No □ Would they prefer an Aboriginal Worker Yes □ No □
Permission to leave a voice / text message: Yes □ No □
Permission to send mail to address provided Yes □ No □
Permission to exchange information with GP/referrer/relevant agencies Yes □ No □
Parent / Guardian /Significant Other Details (if applicable)
Name:_____ Relationship:_____
Contact Tel: _____Email:_____
Is the young person living with a parent Yes □ No □ Is the parent aware of referral: Yes □ No □
Has the young person given verbal permission to contact their parent/guardian: Yes □ No □
Reason for Referral / Drug Use History
Current Medical/Mental Health Problem(s) and Prescribed Medication(s)
Additional Relevant Information
Identified Risks in Working with the Client
History of Aggression/Violence: Yes □ No □ Currently Pregnant: Yes □ No □
History of Self-Harm/Suicidality: Yes □ No □ Positive for BBV: Yes □ No □
History of Unsafe Injecting Practice: Yes □ No Currently Lives Alone: Yes □ No □
Has the client consented to the referral: Yes □ No □