HOLYOAKE
FAMILY • INDIVIDUALS • YOUTH

CONFIDENTIAL - REFERRAL FORM

Referrer's details

Referring Person		DOJ No:			
Organisation					
Contact Details		E-mail		Fax:	
Date of Referral					

Client details

Name		Indigenous Y N			
Date of Birth		Male		Female		Relation to User	
Residential Address					
Telephone No:		Work:			
Country of Birth					
Own use		Other's Use			

Substance Use

Substance	Tick	Amount Used	Frequency Of use	Duration of Use	Additional Information
Alcohol					
Cannabis					
Amphetamines					
Heroin					
Other Opiates					
Hallucinogens					
Party Drugs (XTC, GHB)					
Cocaine					
Prescription Medication					

Mental Health

Symptom	Tick	Additional Information
Suicidal Thoughts		
Suicidal Behaviour		
Self Harm Behaviour		
Aggressive Behaviour		
Anxiety		
Mood Disturbance		
Delusions		
Paranoia		
Hallucinations		
Other		
Known Mental Health Treatment/History		

Reasons for referral

Other agencies involved

Release of information clause

Client to contact WCADS for appt?	Yes	No	Referrer to contact WCADS for appt?	Yes	No
Parents to be involved (if applicable)	Yes	No	Authorisation for WCADS to contact Client	Yes	No

Client Signature....................................... Date............................

Parent Signature ....Date............................
(if client under 18yo)