Referral Form – Queanbeyan AOD Hub

I am:

☐ Referring myself

☐ Referring someone that is accessing services or support in an organisation I work in.

☐ Referring a family member/friend/kin

Referred person's details	
Surname:	Given name:
Address:	
DOB:	Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose
Phone 1: Can leave message and SMS? ☐ Yes ☐ No	Phone 2: Can leave message and SMS? ☐ Yes ☐ No
Email address: Can leave message? ☐ Yes ☐ No	Preferred Method of contact: ☐ Phone ☐ Text ☐ Email
Alternative contact name: Alternative Contact Relationship: Alternative contact Phone number:	
Indigenous Status: ☐ Neither Aboriginal nor Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Prefer not to disclose
Country of birth:	Preferred language:

What would you (or your family/friend/kin) like help with?
Why is the service provider referring you? (if applicable)?
Support is requested for:
AOD Support and Navigation ☐ Mental Health Support ☐ Aboriginal Health Worker ☐ Nursing Support ☐ Lived Experience Peer Support ☐ Residential Treatment ☐ Home Detoxification ☐ Unsure ☐
Have you (or the person I am referring), accessed Drug and Alcohol supports/services before? *If yes, please provide details*

Grand Pacific Health
34 Lowe Street, Queanbeyan, NSW 2620
Ph:02 6298 2900 www.gph.org.au

Health Summary:		
Name of GP:		
Health issues that I experience (or the person I am referring experiences):		
Substance use that impacts me (or the person I am referring):		
Mental health challenges I have experienced (or the person I am referring) has experienced? (include medication/treatment) Mental Health Plan attached? Yes ☐ No ☐		
Legal (if applicable)		
<u>Court</u> Upcoming Court dates: Which Court: Reason for Court:		
<u>Community Based Correction</u> Type of orders in place: Length of order: Requirements:		
Referrer to complete (if you were referred by an organisation or service)		
Name:	Organisation/Practice/Carer:	
Position:	Date:	
Phone	Email	Fax
Written Consent		
☐ I am aware that this referral is being made and that the information in this form will be shared in the process of making this referral. I know I can withdraw my consent at any time.		
☐ I am making this referral for someone else. I have consent from this person to make this referral.		
☐ I am making this referral on behalf of someone whom I am the appointed guardian or carer.		
Verbal Consent		
☐ I have discussed this referral with the person and have obtained their verbal consent to make the referral. I am satisfied that informed consent has been obtained.		
Signature: (Optional)	**Print Name**:	**Date:**

Email this completed form to: queanbeyanaod@gph.org.au or make a phone referral by calling 02 6298 2900.

GPH ensures that personal information is confidential and treated respectfully. Please note that our email service is not encrypted, and therefore we cannot guarantee the security of our email communications. All forms of written communication involve an element of risk that information could be read by someone other than the intended recipient. Some of the risks of using unsecured or unencrypted email include:

- emails can easily be sent to the wrong recipient
- email is often accessed on portable devices, such as smart phones, tablets and laptops, which are easily lost or stolen
- emails can be forwarded or changed without the knowledge or consent of the original sender and is vulnerable to interception.

Please keep this in mind when sharing any personal information.

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