***Please print only from the original, do not photocopy*** *(Tick* 🗹 *as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)*

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| ADS South: ADS North: ADS North West: Phone: 03 6166 0736 Phone: 03 6777 1234 Phone: 03 6464 3131Fax: 03 6173 0805 Fax: 03 6777 5139 Fax: 03 6464 3295 ads.southintake@ths.tas.gov.au alcohol.north@ths.tas.gov.au adsnw@ths.tas.gov.auStatewide Phone: 1300 139 641 (Tasmania Only) |

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| **Consumer Details**  |
| Referral Date |   |
| Title |       |
| Family Name *(print)* |       |
| Given Name(s) *(print)* |       |
| Date Of Birth |       |
| Relationship Status | [ ]  Married [ ]  De facto [ ]  Widowed [ ]  Divorced [ ]  Separated [ ]  Single |
| Gender |       |
| Known alias(es) |       |
| Ethnicity | [ ]  Australian [ ]  Other *(please specify)*       |
| Preferred language | [ ]  English [ ]  Other *(please specify)*       |
| Interpreter required? | [ ]  Yes [ ]  No |
| Aboriginal or Torres Strait Islander Status | [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Both[ ]  Neither [ ]  Not Stated |
| Address |       |
| Phone 1Okay to leave message?SMS appointment reminder? |      [ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| Phone 2Okay to leave message?SMS appointment reminder?  |      [ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| Emergency Contact | Name *(print)*:       | Relationship:       |
| Address:       |
| Phone:       |
| General Practitioner (GP) Details *(Add to Consent to Share Information if relevant)* | Practitioner:       |
| Name of Practice:       |
| Contact Details:       |

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| **Referrer Details:** *(please write “self” in Name box if consumer self refers, and do not complete the remaining two fields)* |
| Print Name, designation and organisation  |            |
| Contact details *(phone, fax, email, postal address)* |       |
| How do you wish to receive feedback? | [ ]  Email [ ]  Phone [ ]  Letter [ ]  Fax |
| **Reason for Referral** |
| Principle drug of concern  |       |
| Frequency and method of use |       |
| Date of last use |       |
| Other drugs of concern  |       |
| **Critical Information** *(please include Alerts, past / current clinical risks and management plans)* |
|       |
| Information attached: | [ ]  Legal Orders/Reports [ ]  Discharge Summary [ ]  Goal Plan[ ]  Other Documentation |

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| **Consent** |
| I, *(print name)* give permission to, *(referrer’s print name and agency)*       to refer me to the Alcohol and Drug Service. I understand that the Alcohol and Drug Service will contact me about this referral.  |
| I give permission for information about my treatment to be shared between the Alcohol and Drug Service and my referrer.I understand that:[ ]  This information is important for my treatment[ ]  Only information that needs to be will be shared[ ]  The Alcohol and Drug Service will use de-identified data from this referral for feedback, research and service improvement. De-identified means that no one will be able to tell that the information is about me[ ]  This agreement lasts for 12 months and can be withdrawn at any time |
| Patient Print Name:       |
| Signature:       | Date:       |
| OR [ ]  tick if consent is given verbally |
| Verbal Consent Taken By *(print name)*:       | Designation:       |
| Signature:       | Date:       |
|       |

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| **ADS USE ONLY (Identify-Situation-Observations-Background-Agreed plan-Read back (ISOBAR) / Identify, Situation, Background, Assessment and Recommendation Repeat (ISBARR)** |
| *Additional Details: for example:**Current substance use – principle drug of concern, frequency & method of use, date of last use, other drugs of concern (this may have changed since initial referral)**Any signs or symptoms of withdrawal?* *Any identified mental health issues?**Any risk factors (for example human immunodeficiency virus (HIV), forensic, pregnancy, homelessness)?**Any legal issues?**Any social supports (do they live on their own, do they have a partner / children)?**Any commitments that will influence appointment times?**Has the consumers had any contact with ADS or another alcohol, tobacco and other drugs (ATOD) service?**Does the consumer have a discharge plan* |       |
| ***If you require more space, please use progress notes.*** |
| Clinician Name *(print)*:       | Designation:       |
| Signature:       | Date:       |