***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)*

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

|  |  |  |
| --- | --- | --- |
| **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 1  Okay to leave message?  SMS appointment reminder? | Yes  No  Yes  No | |
| Phone 2  Okay 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: |
|  | |

|  |  |  |
| --- | --- | --- |
| **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: |