

Referral made from Community

Surname _____ Given Name _____
 Date of Birth _____ Gender _____ MIN _____
 Country of Birth _____ Cultural Identity _____
 Contact Address _____
 Phone Number _____ Date of Referral _____

Referrer's Contact Details

Name _____ Position _____
 Email _____
 Phone _____ Mobile _____

Current Sentence & Offending History

Release Date _____ Length of Sentence _____
 Most Recent Conviction _____ Longest Period Out of Custody _____
 LSI-R Score _____ Low Medium Medium-High High Very High
 Past Offences _____
 Any Outstanding Charges (please provide details) _____
 Parole? Yes No Duration of Parole : _____
 History of Violence in Custody or Community: Yes No
 If yes please provide details _____

Eligibility Criteria

| | Yes | No |
|---|--------------------------|--------------------------|
| MUST have a history of problematic AOD use | <input type="checkbox"/> | <input type="checkbox"/> |
| MUST be voluntarily seeking support | <input type="checkbox"/> | <input type="checkbox"/> |
| MUST have a history of offending behaviour linked directly or indirectly to AOD use | <input type="checkbox"/> | <input type="checkbox"/> |
| MUST belong to one of the following groups which impacts upon their ability to access mainstream AOD services: | | |
| Cognitive Impairment If yes please provide diagnosis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Health If yes please provide diagnosis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Women with dependent children | <input type="checkbox"/> | <input type="checkbox"/> |
| Aboriginal | <input type="checkbox"/> | <input type="checkbox"/> |

Risk (Please attach any assessment relevant to risk)

Does the person have a record of risk?

A) To themselves: _____

B) To others: _____

Please outline any challenging behaviours or violent history _____

Offending History *Please describe link between AOD use and offending behaviour*

Treatment History *Please describe the person's difficulties accessing mainstream AOD services*

Drugs & Alcohol

Please describe the person's AOD history _____

Please describe the person's current AOD use _____

Please outline the specific assistance required _____

*Note to referrer: With client consent you can provide any additional documents to support the referral.
Additional documents may also assist in assessing client support needs.*

*I _____ (print name) am voluntarily seeking support.
I hereby give permission for my personal information to be accessed by Community Restorative
Centre (CRC), in order to assist with my case management and AOD support. I agree that my details
be placed on the CRC database and NADAbase where my details will be de-identified (name not
associated with information) when used for data collection.*

Client Signature

Worker / Referrer Signature

Date

Date

NOTE: CLIENT MUST SIGN CONSENT BOX ABOVE IN ORDER FOR REFERRAL TO BE CONSIDERED