Sydney Transitional AOD Referral Form

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	☐	☐
MUST be voluntarily seeking support	☐	☐
MUST have a history of offending behaviour linked directly or indirectly to AOD use	☐	☐
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 _____	☐	☐
Mental Health If yes please provide diagnosis _____	☐	☐
Women with dependent children	☐	☐
Aboriginal	☐	☐

Risk (Please attach any assessment relevant to risk)

Does the person have a record of risk?

A) To themselves: _____

251 Canterbury Road
Canterbury NSW 2193

Postal Address
PO Box 258
Canterbury NSW 2193

phone (02) **9288 8700**
fax (02) **9211 6518**
email aod.transition@crcnsw.org.au

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

Please send completed form and supporting documents to aod.transition@crcnsw.org.au