AOD Transition Referral Form

Referrer Details

Date of Referral:

Referrer Name:

Organisation/Correctional Centre:

Referrer Phone:

Referrer Position:

Referrer Email:

Eligibility

If no to eligibility questions below, then client is not eligible for this program. See note below.

Client is aged 18 years old or older?	◯ Yes	◯ No
Client is voluntarily seeking AOD support?	◯ Yes	◯ No
Client is currently in custody or has previously been in custody?	◯ Yes	◯ No
Is release date confirmed?	◯ Yes	◯ No
Is history of offending behavior linked directly or indirectly to AOD use?	◯ Yes	◯ No
Client is residing in, or intending to reside in upon release, Greater Metropolitan Sydney?	◯ Yes	◯ No

Select which area below.

- ◯ Eastern suburbs
- ◯ Inner West
- ◯ Northern Sydney
- ◯ South Eastern Sydney
- ◯ Sydney
- ◯ South Western Sydney (part)
- ◯ Western Sydney (part)

Suburb:

Note

CRC's AOD program provides individual counselling appointments for up to 12 months focusing on drug and/or alcohol issues. We will do our best to support clients with additional barriers they are facing, such as accommodation and financial difficulties. The primary focus of CRC's AOD program however, is AOD counselling and goals relating to AOD use. We can suggest other services to try, should a client be seeking case management assistance only.

Client Details

Name: Date of Birth:

Address:

Mobile Phone: MIN #:

Gender identity: ◯ Male ◯ Female ◯ Non-binary ◯ Prefer not to say ◯ Other

Cultural identity: ◯ Aboriginal ◯ Torres Strait Islander ◯ Other

Country of birth: Languages spoken:

Interpreter required? ◯ Yes ◯ No If yes, preferred language:

Children: ◯ Yes ◯ No Ages: Living with:

Health conditions: ◯ Yes ◯ No Specify:

Disability or impairment: ◯ Yes ◯ No Specify:

Mental Health Condition(s): ◯ Yes ◯ No Specify:

Prescribed medication: ◯ Yes ◯ No Specify:

Is there anything further about the client's identity or experience they wish to share?

AOD Treatment history and current use

Please describe previous substance use, history of treatment and current use:

What is the primary drug of choice, including alcohol?

Method of use: ◯ Ingest ◯ Smoke ◯ Inject ◯ Sniff (powder) ◯ Inhale (vapour)

◯ Other

Any other drug(s) used?

Please outline the specific assistance required:

Current situation

◯ In custody: sentenced ◯ In custody: remand ◯ Post-release: in community ◯ Post-release: bail

Note

CRC's AOD program cannot accept referrals where the client is on remand and has no known release date.

Current/most recent charge/charges:

Sentence start date: Release date:

Length of full sentence:

◯ Parole ◯ ICO ◯ CCO Duration:

Will the client be electronically monitored? ◯ Yes ◯ No

Is the client a protected person on an AVO? ◯ Yes ◯ No

Will the client need to adhere to conditions of an AVO? ◯ Yes ◯ No Duration:

Housing

What will be/what is the client's current housing situation?

◯ Homeless ◯ Temporary accommodation ◯ Family/Friends ◯ Return to previous accommodation

Post release address, Suburb or Community:

Slept rough/couch surfed/stayed in non-conventional accommodation in last 12 months? ◯ Yes ◯ No

Time since last permanent residence: Suburb:

Offending history

Number of previous incarcerations: Juvenile: Adult:

Past offences:

Is the client on the child protection register? ◯ Yes ◯ No

Does the client have any outstanding charges? ◯ Yes ◯ No

Please provide details of outstanding charges below (court dates, stage of legal process):

Offending history continued

History of violence in Custody or Community? ◯ Yes ◯ No

Please provide details below:

Other agencies or programs providing support to client (including recent referrals)

Please provide details of any support client receives from any other agencies or programs?

Consent

I, _____ (print name) am voluntarily seeking support. I hereby give permission for my personal information held by Corrective Services NSW to be accessed by Community Restorative Centre (CRC), in order to assist with my AOD counselling and other 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 _____

Date

Worker/referrer signature _____

Date

Note

Client must sign consent box above in order for referral to be considered. Please email completed form and supporting documents to: aod.transition@crcnsw.org.au