Referral Form

Banyan House is a medium to long term residential drug and alcohol rehabilitation facility that uses the Therapeutic Community model of treatment. We accept referrals from:

- You - self-referral
- Family and friends
- General Practitioners (General Practitioners should attach a mental health care plan (if applicable) for the client to this referral form)
- Allied Health Professionals
- Community-based agencies
- Legal representative
- Other agencies

Each referral is assessed by one of our team members. If they consider the client is suitable for the Therapeutic Community Program, they will be offered an appointment to discuss the possible placement in Banyan House.

Please note: The person being referred, must be aware you are making this referral. Our staff can only talk to the referred person.

Please complete this form with as much detail as possible and one of our team will contact you.

Title: ☐Mr ☐Ms ☐Mrs

First Name: _____

Last Name: _____

Date of Birth: _____
(DD/MM/YYYY)

Phone Number: _____

Email: _____

_____

State:
☐ACT
☐NSW
☐NT
☐QLD
☐SA
☐TAS
☐VIC
☐WA

Known address: _____
(Street)

Suburb _____

Postcode _____

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Gender: ☐Male ☐Female ☐Not stated/Not known/Inadequately described

ATSI Status:
☐Aboriginal
☐Both Aboriginal and Torres Strait Islander origin
☐Torres Strait Islander
☐Neither Aboriginal nor Torres Strait Islander origin
☐Not stated/Unknown

Language spoken at home: _____

Marital Status:
☐De Facto
☐Divorced
☐Married
☐Single
☐Separated
☐Widowed
☐Not stated/unknown

Do you have any Dependents: ☐Yes ☐No Number of Dependents: _____

Name of GP Clinic: _____

GP Name and Surname (if known): _____

GP Phone Number: _____

GP Email (if known): _____

GP Fax (if known): _____

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Drug Information

Primary Drug: _____

Method of Use:
- ☐Ingest
- ☐Eat/Drink
- ☐Inhales
- ☐Injects

Date Last Used: _____
DD/MM/YYYY

Frequency (days per week)
If Zero please specify
Amount & Frequency of current use: _____

When using this drug, in the last 12 months, the client feels:

Developed tolerance?	☐Yes	☐No
Experienced Withdrawals?	☐Yes	☐No

Withdrawal symptoms: _____

Other Drugs: _____

Client Type: **Please tick all that apply**
- ☐Both own and other's alcohol or other drug use
- ☐Other's alcohol or other drug use
- ☐Own alcohol or other drug use
- ☐Mental Health

Referral Date: _____
Referral Agency: _____
Referrer Telephone: _____
Notes: _____

Legal Concerns

Legal Concerns: Please note an automatic exclusion criteria applies for any crimes against children, sexual offending, murder/manslaughter, arson and any serious crimes of violent.

Previous AOD history/treatment

Have you attended detox/treatment in the past? Please list below.

Current Medical/Mental Health problems

Please provide details plus medications you need to bring with you into the program.

Additional relevant information