

Aranda House Therapeutic Community | Referral Form

The following information is required prior to assessment; all sections must be completed emailed with supporting documents.

REFERRER INFORMATION

Referral Date: ____ / ____ / ____

Self-Referral: ☐ YES ☐ NO

Referring Agency: _____

Name: _____

Position: _____

Telephone: _____

Email: _____

APPLICANT'S INFORMATION

Surname: _____

Given Name: _____

Also known as: _____

DOB: ____ / ____ / ____

Gender Identity: _____

Marital Status: _____

Dependants: _____

Phone Number: _____

Aboriginal/Torres Strait Islander: YES NO

Other: _____

Usual Address: _____

Employment/Study _____

Interpreter requested: ☐ Yes ☐ No

Language required: _____

Interpreter used: ☐ Yes ☐ No

CURRENT LEGAL SITUATION

The applicant is currently:

☐ Incarcerated sentenced

☐ Incarcerated remand

☐ Released (no conditions)

☐ Supervised by Community Corrections

☐ Parole

☐ Bail

☐ Other: _____

Charged with: _____

Sentenced for: _____

Supervision Order: _____

Incarceration Date: ____ / ____ / ____

On remand, next court: ____ / ____ / ____

Eligible for Parole: ____ / ____ / ____

Release Date: ____ / ____ / ____

DRUG USAGE

Principal Drug of Concern: _____

Last time used or consumed: _____ Usual Quantity: _____

Method for digest eg: smoke/inject/drink _____

REASON FOR REFERRAL / ADDITIONAL INFORMATION

ORDERS PREVENTING CONTACT WITH OTHER PEOPLE

Are there any legal / protection orders (e.g. Domestic Violence Orders) in place? ☐ Yes ☐ No

Is the Order ☐ No Contact ☐ Non-Intox Against the referring applicant? ☐ Yes ☐ No

Other individual _____

ADDITIONAL INFORMATION

	Yes	No	Details
Alerts			<i>If yes, what are these?</i>
Medical Conditions			
Mental Health Conditions			
Family Issues			<i>Eg: Family Law Matters, children in care</i>
Life and Death Concerns			<i>Eg: Payback</i>
Areas/Places of Concern			<i>Eg: does the client have any areas of restriction? If the client has a DVO, are there any areas of concern.</i>

FURTHER DOCUMENTS ATTACHED (IF APPLICABLE)

☐ Mental Health Report(s)

☐ Cognitive assessment

☐ Medication Management Plan

☐ Mental Health Plan

Signed: _____

Name of Referrer: _____

Date: _____

Whilst the Case Management team understands the sensitivity and shame around providing this documentation and details, DASA require all relevant information to assess, deem suitability, ensure conflicts of interest between clients and visitors are not crossed and the needs of the individual are met in their Case Management.

Not providing this information will delay assessment and progression of the referral.

Aranda House Therapeutic Community | Consent Form

APPLICANT CONSENT TO SHARING OF:

- Complete criminal history
- Sentencing Remarks
- Conditions of Release
- Relevant orders (Bail, Susp. Sentence, Parole)
- Domestic Violence order/s

The purpose of this form has been discussed with me, and I give permission for the above information regarding myself to be exchanged and collected with the Drug & Alcohol Services Australia (DASA), the referring agency and the Aranda House Case Management Team for the purpose of considering my suitability for the program.

Signature of applicant: _____

Verbal consent: ☐ Yes ☐ No

Date: ____/____/____

Signature of referring person: _____

Date: ____/____/____

APPLICANT CONSENT TO SHARING OF PERSONAL INFORMATION:

The purpose of this form has been discussed with me, and I give permission for personal information regarding myself to be exchanged and collected with the Drug & Alcohol Services Australia (DASA), the referring agency and the Aranda House Case Management Team for the purpose of considering my suitability for the program.

Signature of applicant: _____

Verbal consent: ☐ Yes ☐ No

Date: ____/____/____

Signature of referring person: _____ Date: ____/____/____

APPLICANT CONSENT PARTICIPATION IN PROGRAM:

I understand and consent to engage and participate in the DASA Aranda House Therapeutic Community program.

Signature of applicant: _____

Verbal consent: ☐ Yes ☐ No

Date: ____/____/____

Signature of referring person: _____ Date: ____/____/____

Email referral to: intake@dasa.org.au

Following receipt of referral and assessment will be booked. (Acceptance to the program is subject to assessment of suitability and consultation with the Aranda House Case Management Team).

CLIENT DEBT – DASA Use

Does this client have a Debt with DASA? ☐ Yes ☐ No

If so, how much? _____