PO Box 57 Alyangula NT 0885
P: 0457 847 608
E: grooteintake@dasa.org.au

Anindilyakwa Healing Centre | Referral Form

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

REFERRER INFORMATION:

Referral Date: ____ / _____ / _____ Organisation: _____

Name: _____ Position: _____

Telephone: _____ Email: _____

APPLICANT'S INFORMATION:

Surname: _____ Given Name: _____

Also known as: _____ DOB: ____ / _____ / _____

Mothers Name: _____ Father's Name: _____

☐ Aboriginal or ☐ Torres Strait Islander Community: _____

Language(s) spoken: _____

Interpreter requested ☐ Yes / ☐ No Language required: _____

Interpreter used ☐ Yes / ☐ No If No, Why: _____

Phone Number: _____ Address: _____

Suburb: _____ Postcode: _____

CURRENT LEGAL SITUATION

The applicant is currently:

☐ Incarcerated sentenced
☐ Released (no conditions)
☐ Parole
☐ Other: _____
☐ Incarcerated remand
☐ Supervised by Community Corrections
☐ Bail

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: _____

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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			*If yes, what are these?*
Medical Conditions			
Mental Health Conditions			
Family Issues			*Eg: Family Law Matters, children in care*
Life and Death Concerns			*Eg: Payback*
Areas/Places of Concern			*Eg: does the client have any areas of restriction? If the client has a DVO, are there any areas of concern.*

FURTHER DOCUMENTS ATTACHED (IF APPLICABLE)

☐ Mental Health Report(s)
☐ Medication Management Plan
☐ Cognitive assessment
☐ 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.

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PLAN B: ALTERNATIVE CARE AND SUPPORT PLAN

Immediate Contact Information

Primary Contact for Emergency Exit:

Name: _____

Relationship to Participant: _____

Phone Number: _____

Address: _____

Preferred Alternative Accommodation

Location: _____

Contact Person: _____

Phone Number: _____

Participant Agreement - Exit Plan Awareness:

The participant agrees to the Plan B process outlined above.

Signature of Participant: _____

Date: _____

CLIENT DEBT – DASA Use

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

If so, how much? _____

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Anindilyakwa Healing Centre | 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 Anindilyakwa Healing Centre Referral Group for the purpose of considering my suitability for the Anindilyakwa Healing Centre 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 my personal information regarding myself to be exchanged and collected with the Drug & Alcohol Services Australia (DASA), the referring agency and the Anindilyakwa Healing Centre Referral Group for the purpose of considering my suitability for the Anindilyakwa Healing Centre 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 Anindilyakwa Healing Centre - Alternative to Custody program on Groote Eylandt.

Signature of applicant: _____ Verbal consent: ☐ Yes ☐ No

Date: ____/____/_____

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

Email Referral to: grooteintake@dasa.org.au

Following receipt of referral and assessment will be booked. (Acceptance to the program is subject to assessment of suitability and at the discretion of the Anindilyakwa Referral Group)