Baroona Youth Healing Place

Njernda Aboriginal Corporation

Client assessment and referral

Referrals

In order for this referral to be assessed:

- all sections must be completed.
- all information provided must be true and correct
- referrals must comply with privacy requirements.

Acceptance will also depend on the client agreeing to the Rights and Responsibilities Charter associated with Njernda Aboriginal Corporation's Baroona Youth Healing Place service. These protect the safety and welfare of clients and staff.

Failure to comply with these requirements may result in automatic rejection of this referral

On completion, return referral by fax or email to:

Keith Hearn
Baroona Manager
Baroona Youth Healing Place
Fax: (03) 5480 9522
E-mail: KeithH@njernda.com.au

If you have any questions you can contact Baroona on **(03) 5481 3100**

Acceptance of this referral does not guarantee acceptance into Baroona's programs.

Formal advice of the acceptance or rejection of this referral will be provided as soon as possible. Please be aware that Njernda Aboriginal Corporation is unable to accept responsibility for insecure transfer of personal data.

BAROONA YOUTH HEALING PLACE

Referral and assessment form

Client Surname: _____

Given names: _____

Nickname/preferred name:_____

DOB: _____**Age:** _____

Gender: Male / Female

Address: _____

_____**Postcode:** _____

Telephone: _____**Mobile:** _____

Emergency contact: Name: _____**ph.:** _____

Address: _____

Relationship to client: _____

Aboriginality: (please circle) Aboriginal Torres Strait Islander Not Aboriginal/Torres Strait Islander

Language/s: preferred language: _____**other:** _____

Date of Referral:_____

Date of Assessment:_____--

Referral source:_____

Referrers contact details: _____

Where was assessment completed?_____

Assessor's details (Name): _____**Ph:**_____

Organisation: _____

Is there anyone client does not want to know about their contact with this service: YES / NO

If yes, why? _____

_____

Names of these people: _____

_____

Does client need identification: if so what I.D. is required? _____

_____

_____

Does client have a confirmation of Aboriginality or Torres Strait Islander form? YES / NO

If No, does client want Njernda to assist them get the Confirmation form? YES / NO

CENTRELINK: Is client currently in receipt of Centrelink payments YES / NO

If YES, what payment type: (Newstart, Abstudy, Sole Parent, etc)_____

If NO, is client eligible for these payments and if so note what steps are required for payment to commence?

_____

_____

If client is not eligible, please explain why and note any steps need to be taken to obtain eligible benefits.

_____

_____

HEALTHCARE No: ☐☐☐ ☐☐☐ ☐☐☐☐

MEDICARE No: ☐☐☐☐☐☐☐☐☐☐ **Reference No;** ☐

DETAILS OF SUBSTANCE USE

(i) Alcohol & Drug Use History *(Tobacco / Alcohol / Cannabis / Amphetamines / Opiates / Cocaine / Ecstasy / LSD / Hallucinogens / Benzodiazepines / Solvents (Petrol/Glue/Paints) / Other non-prescribed drugs)*

All Drugs Used

SUBSTANCE									
Age when first used substance?									
Age of first regular use?									
Method of use (inject, ingest, snort etc)?									
Age first injected?									
Average daily use? (grams) (no. of injections - no. of drinks) (dollars spent)									
How many days used in past 7 days?									
Days used in past 4 weeks?									
When was the last time used?									
Over what period of time has been using daily?									

(ii) Other Comments Regarding Substance Use (e.g. pattern of use, mixing drugs, substitution, risk taking behaviours like share equipment, blackouts, poly drug use)

(iii) Context of Substance use: (with anyone else, in groups or on own, where, when)

(iv) Reason(s) for use: (What is the client's experience of using drugs either positive or negative functionality ['to feel normal', 'to cope', self medicating for pain or mental health, 'dutch courage']

(v) What does client want to do with their drug use: (stop, reduce, continue using, etc)

(vi) Previous Alcohol & Drug Interventions (e.g. past withdrawal history - date, setting, substance, complications of withdrawal, medications used, complementary/alternative treatment, outcome; type - counselling, self help groups, residential rehabilitation, methadone or other substitution therapy, their own efforts at cutting down/abstaining, previous personal best in achieving/maintaining abstinence or controlled use?) include what worked, what didn't work.

MEDICAL HISTORY

(i) Current problems in need of immediate attention (include history of condition, investigations and treatments. DO NOT INCLUDE PSYCHIATRIC CONDITIONS HERE -Refer to page11

Tick as appropriate

☐	Allergies	☐	Gastrointestinal problems	☐	Skeletal injuries
☐	Seizures/fits/epilepsy	☐	Cardiac problems	☐	Diabetes
☐	Liver Disease	☐	Respiratory (e.g. asthma)	☐	Pregnancy
☐	Dental	☐	Chronic Pain		
☐	Head Injuries	☐	Other(specify)		

(ii) Past Relevant Medical History (include pregnancies/outcome, add more info on ticked boxes above if required)

(iii) General Hospital Admissions (Specify e.g. date, hospital, reasons for admission, length of stay; include ambulance attendances)

(iv) Other comments (including impact of substance use on general health, weight loss, sleep patterns)

(v) Physical Health (diet, nutrition, hygiene)

(vi) Last medical check up: (is a further medical check required) **Action taken if needed.**

(vii) Current Prescribed and other Medication (Including methadone, psychiatric medication, over-the-counter drugs, complementary medicines e.g. herbs, vitamins, 'alternative' treatments)

Medication	Prescribed Dose	Taking medication as prescribed? (Y/N) If no, reason?	Duration of treatment?	Reason for Prescription?	Prescribing Doctor/Health Practitioner?

(viii) Past History of Prescribed Medication & Reason Prescribed (include all medications, and does medication impact on drug use, or is medication also part of substance use problems that can be included in substance use history?)

LEGAL HISTORY

(i) Current legal commitments: (e.g. current charges, bail conditions, court and court date)

_____

_____

Court: _____ **Court date:** _____

Legal Representative: _____ **Phone**: _____

(ii) Current Court orders – CBO, ICO, adult parole, juvenile parole or other JJ orders. (What are the conditions on these orders; e.g. alcohol and drug assessment, anger management, cognitive skills).

_____

_____

CCS/JJ office: _____ **Workers name:** _____

Phone: _____ **mobile:** _____

(iii) Outstanding Warrants: (or are there any missed court dates, which police station)

_____

_____

(iv) Other Court Jurisdictions - Family court, Children's court, civil actions, conditions of orders

_____

_____

(v) History of Violence/Present Risk to Others (includes Intervention orders / assault / domestic violence / threats to kill / sexual offences / offences against other persons, especially children / persons at risk - children, spouse, others/driving under the influence)

_____

_____

_____

(vi) Current risk to client from others (Threats from others/assault by others/victim of domestic violence)

_____

_____

(vii) Previous criminal history in brief; (Charges; juvenile justice orders, corrections orders, jail)

_____

_____

_____

Is Client eligible for Drug Diversion: (please circle) Yes / No (if Yes or unsure please contact the Aboriginal Diversion Unit: ph. 03 9510 3233).

PSYCHOSOCIAL HISTORY

(i) Family Tree/Genogram (including any family history of alcohol and drug problems as well as supportive extended family members or who raised the client)

(ii) Family Relationships / Children (Include past relationships, nature of relationships; child care responsibilities. Does client require child care when attending A&D services? Child Protective Services involvement/other dependents. Impact of substance use.)

(iii) If DHS Protective services involved:

Name of worker: _____

Region: _____ **Phone:** _____

(iv) Family of Origin (Clan, Mob, land/ country of birth / relationships / roles, include cultural/ethnic-specific issues,)

(v) Family Dynamics: (supports, areas of conflict, who does client live with?)

(v) Stolen Generation (Is client or family/community member part of the Stolen Generations and is Link Up or Bringing them Home program required?)

(vi) Family and Significant Other Involvement (Are there significant others that the client would like involved in their treatment? Please specify name, relationship to client (elder, relative; uncle or aunty, partner, friend), and in what way would they like them to be involved?)

Name of significant other	Relationship to client	In what way would the client like them involved?
1.		
2.		
3.		

Other family or community members (significant others) that can support client (elders, aunties, uncles, etc)

_____

_____

(vii) Peer Networks (friends or family, clubs or groups, school, workplace etc)

_____

_____

(viii) Finances / Employment (e.g. source of income, employment history, include CDEP if involved, add impact of substance use on employment)

_____

_____

(ix) Education/Training (e.g. highest level of education achieved age left school, reading & writing skills, ESL?, other training or education programs attended after leaving school)

_____

_____

(x) Recreational Interests (e.g. past & present / hobbies / sports / gym / music / reading / art / fishing / motorbikes / clubs / teams / nightclubs / gambling - impact of substance use on these)

_____

_____

(xi) Accommodation (e.g. safe, stable, supportive, crisis accommodation, homeless/at risk of homelessness, substance use in household, impact of substance use on stable accommodation)

_____

_____

PSYCHIATRIC HISTORY

(i) Is client currently receiving psychiatric treatment support? (please circle) **YES / NO**

If yes; please list Area Mental Health Service, contact details and treating psychiatrist. (if prescribed medication include in medication prescribed section)

Name: _____ **Phone:** _____

Area Mental Health Service: _____ **Phone:** _____

(ii) Previous psychiatric history

_____

_____

_____

(iii) General presentation (is client aware of what is going on at present, are they in a dishevelled state)

_____

_____

(iv) Abnormal thought processes (e.g. confusion, disorientation)

_____

(v) Style of relating (e.g. evidence of attention problems, level of engagement)

_____

_____

(vi) Coherence / Level of awareness (understands or does not understand process clearly)

_____

_____

(vii) Mood (agitated, relaxed, happy to participate, angry, blaming of others)

_____

_____

(viii) Impact of substance use on mental state (psychotic episodes, induces abnormal thoughts, anger/violent outbursts, depressive states)

_____

_____

_____

(ix) Suicide / Self-harm risk assessment (Tick applicable items) this is to help determine if client is currently feeling suicidal or has felt suicidal in the past)

- ☐ Sense of hopelessness/worthlessness? _____
- ☐ Ideation (Do you ever think about killing/harming yourself*)_____
- ☐ Intent (Do you want to kill/harm yourself?)_____
- ☐ Plan (How would you do it?)_____
- ☐ Lethality (Is the method likely to be lethal?)_____
- ☐ Accessibility?_____
- ☐ Previous attempts? _____
- ☐ Suicide/attempted suicide of significant other?_____

(*if evidence of suicidal ideation, include it in the case summary)

(x) Is a full psychiatric assessment required? (please circle) **YES / NO**

If Yes, action taken (e.g. referral to CAT team/psychiatrist/psychologist for full examination, if on bail or remanded court can order a Forensiccare assessment)

_____

_____

_____

Intellectual Disability Service (IDS) Registered: (please circle) **YES / NO**

If yes does client have IDS case management support and which regional office:

Worker's name:_____ **Phone:**_____

Regional office:_____ **Action taken:** _____

_____

_____

_____

Does client have an Acquired Brain Injury (ABI) : YES / NO / UNSURE

If yes or unsure does client require an ARBIAS assessment for case management support.

Action taken: _____

_____

_____

_____

_____

Support Services

Are there other workers with whom this young person currently has contact?
(e.g. Indigenous (Koori) worker; protective worker, juvenile justice worker, CCS officer, housing worker, social worker, general practitioner, case manager, religious worker, Aboriginal Co-op, youth worker). Which, if any, of these services or people are willing and able to assist with community transition at the end of the young person's stay at Baroona?

Name ______________________________ Phone ____________________

Position/relationship to client: ______________________________

Organisation: ______________________________

Address : ______________________________

Postcode: ____________ Fax: ______________ Email: ____________________

Name ______________________________ Phone ____________________

Position/relationship to client: ______________________________

Organisation: ______________________________

Address : ______________________________

Postcode: ____________ Fax: ______________ Email: ____________________

Name ______________________________ Phone ____________________

Position/relationship to client: ______________________________

Organisation: ______________________________

Address : ______________________________

Postcode: ____________ Fax: ______________ Email: ____________________

Name ______________________________ Phone ____________________

Position/relationship to client: ______________________________

Organisation: ______________________________

Address : ______________________________

Postcode: ____________ Fax: ______________ Email: ____________________

ASSESSMENT, SUMMARY & TREATMENT PLAN

(i) Comprehensive assessment summary of client, covering essential details (e.g. general presenting problems, relevant A&D history-including drug/s of choice and their function e.g. positive or negative; medical, psychiatric (including diagnoses and psychosocial history); connection with family, mob, clan, language, land & country; client's motivation; barriers to treatment; stressors and where are they at in the 'stages of change model'.

(ii) Main issues identified by worker (to assist with formulation of individual treatment plan)

(iii) Client's strengths: (what strengths client has that can be identified to help in treatment plan; i.e. positive relationships with either family, elder, mob or clan member. Connection with spirit and/or land or language. Previous positive attempts at recovery. Does client demonstrate resilience and/or strong survival skills)

(iv) Individual AOD Treatment Plan (ITP): (e.g. harm minimisation strategies, e.g. reducing use, preparation for withdrawal, cessation of use, reducing criminal activities, anger management, etc.: relapse prevention strategies, e.g. self talk, identifying triggers and plans to deal with them: positive life skills alternatives, e.g. stress management, relaxation, exercise, diet alternative social activities: other goals may include employment, education and training, secure housing, joining sporting groups or clubs, re-connection with land and/or community and/or family, etc.)
Note: not too many goals at one time.

Other Treatment comments/notes:

BAROONA EXIT PLAN or EMERGENCY DISCHARGE PLAN

Resident Name:		**Date of Birth:**	**____/____/**

Details of Legal Guardian (for minors) or contact person when leaving Baroona			
Contact Name:		**Relationship to Resident:**	
Home Phone:		**Business Phone:**	
Mobile:		**Other:**	

This plan is designed to give the young person support for when their stay at Baroona is completed or in the event they have to leave Baroona on short notice. This plan needs to have been discussed with all people concerned and agreed on prior to coming to Baroona.

Plan for exit or in case of emergency discharge:
Address: (where will they live) _____ _____ Who will be supporting young person? (can be written on page 13 Support services) What supports may need to be put in place? What activities are available or should be arranged?

I, _____ (name of resident) agree to the above plan in the event that I decide to leave, or staff request that I leave immediately.			
Signed:		**Date:**	**____/____/**

For Minors			
I, _____ (name of guardian) agree to the above plan in the event that _____ (name of resident) decides to leave Baroona early of their own choice, or is asked to leave by staff.			
Signed:		**Date:**	**____/____/**

BAROONA YOUTH HEALING PLACE

PERMISSION TO OBTAIN & RELEASE INFORMATION

I, _____ of _____

_____have agreed to the following.

1. **TO OBTAIN OR RELEASE INFORMATION ABOUT ME**
   I give permission to Njernda Aboriginal Corporation's Baroona Youth Healing Place to:
   a) obtain information about me from, and
   b) release information about me to:
      - any drug treatment service or
      - medical practitioner or psychiatric service involved in my care, or
      - those people or organisations named below, which I have initialled:

INDIVIDUAL OR AGENCY:	DATE	INITIALS

2. **HOW THIS INFORMATION WILL BE USED:**
   I understand that the information will only be used for the following purposes:
   a) to prepare and co-ordinate a treatment/case plan
   b) to prepare and provide reports to Courts at my request
   c) to provide treatment progress information to those people or organisations listed above as agreed to by me and Njernda Aboriginal Corporation's Baroona Youth Healing Place.

The content of this authorisation has been explained to me and I understand the nature of the information that will be received and released about me. I also understand that this consent form can be altered or changed at any time during the course of treatment.

Client's signature: _____ Date: _____

Witness name: _____

Witness signature: _____ Date: _____