



REFERRAL FORM

Southcity Clinic
Level 1
61-69 Brighton Rd
Elwood VIC 3184
☎ **9525 7399**
📠 **9525 7369**

Referral Date ____/____/____

CLIENT DETAILS

Given name	Family name
Address	
Phone	Mobile
D.O.B. ____/____/____	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>

REFERRED BY

Name		
Practice/Service		
Address		
Phone	Fax	Email

SUBSTANCES OF CONCERN

Tick all appropriate

Alcohol	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Other opiates	<input type="checkbox"/>
Solvents/inhalants	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>

EMPLOYMENT STATUS

Employed Casual Unemployed Other

PRIORITY CHECKLIST (check all applicable)

Client is pregnant	<input type="checkbox"/>
Childcare responsibilities	<input type="checkbox"/>
Children may be at risk	<input type="checkbox"/>
Client is currently injecting drugs	<input type="checkbox"/>
Client has physical health concerns	<input type="checkbox"/>
Clients has mental health concerns	<input type="checkbox"/>
Risk of self harm/suicide	<input type="checkbox"/>
Client may be a threat to others	<input type="checkbox"/>
Outstanding legal issues	<input type="checkbox"/>
Homelessness/no fixed abode	<input type="checkbox"/>

SUBSTANCE USE AND PROBLEMS (what are your concerns – list or attach documentation)

CURRENT PRESCRIBED MEDICATIONS

(list or attach documentation – include medication and dose)

OTHER SERVICES/AGENCIES INVOLVED

(psych services, pain clinic, psychologist, etc)