

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 _____

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): _____

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
