

**The Cottage**

**Adelaide LGBTIQ AOD Service**

**CLIENT REFERRAL FORM**

CONSENT: The client/s named below has provided this worker with verbal / signed consent to disclose information and refer them for services at Thorne Harbour Health.

**Client details**

|  |  |
| --- | --- |
| First Name |  |
| Surname |  |
| DOB |  |
| Phone and email |  |
| Does the client identify as being LGBTIQ? |  |
| Preferred contact method/alternative contact |  |
| Any other relevant Information? |  |
| Pronouns |  |

Is an interpreter required? Y or N If Y, Language:

**Referring organisation/service details. Who is referring this client?**

|  |  |
| --- | --- |
| Worker name |  |
| Organisation |  |
| Type of service (e.g., housing, mental health) |  |
| Are you staying involved in providing care? |  |
| Do you want to be informed of outcome of referral? |  |

**Are there any other current supports? (Psychologist, case manager, Child Protection – please provide their contact details if available)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Worker Name | Role | Organisation | Contact # | Consent to contact |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

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| --- |
| **Summary of presenting issues, risks and primary substance of concern:** |

Please email referral to **aodsaintake@thorneharbour.org**