



Alcohol & Drug Service

REFERRAL TO ALCOHOL & DRUG SERVICE

(ADS Use Only)

*Affix patient identification label here

Client ID/ADIMS:

Family Name:

Given Name(s):

DOB: ____ / ____ / ____ Sex: F M

Please tick box

- Alcohol & Drug Service (North)
13 Mulgrave Street, Launceston 7250
Fax: 6336 5567 ☎: 6336 5577
- Alcohol & Drug Service (North-West)
11 Grove Street, Ulverstone 7315
Fax: 6429 8599 ☎: 6429 8555
- Alcohol & Drug Service (South)
GPO Box 125, Hobart 7001
Fax: 6230 7922 ☎: 6230 7901

Date of referral: ____ / ____ / 20____

Client Details

Family Name:

Given Name(s):

Title: Mr Miss Ms Mrs DOB: ____ / ____ / ____ Age: ____ (yrs)

Address:

Suburb: State: Postcode:

Phone (H): OK to leave message? Yes No

Phone (W): OK to leave message? Yes No

Mobile: Appt SMS reminder? Yes No

Referrer Details

Name and Designation:

Organisation:

Telephone: (Business) (Fax)

Email:

Referral Details

Principal drug of concern:

Frequency & method of use:

Other drugs of concern:

Reason for referral:

Critical Information (**Alerts**): Past & current clinical risks and management plans (**This information MUST be provided**)

Information Attached:

- Legal Orders/reports
- Discharge Summary
- Goal Plan
- Other Documentation

How do you wish to receive feedback? Email Phone Letter Fax

Consent to Provide Information (MUST BE PROVIDED)

I (client name), consent to (referrer's name)
 of (organisation)..... providing information regarding myself to:
 Alcohol & Drug Service, for the purposes of referral. I understand that this consent will expire 12 months from the date of signing or on the termination of my contact with Alcohol & Drug Service (North/North West), whichever occurs first. I understand that I may withdraw this authorisation, in writing, at anytime prior to the expiry date, except where action has already been taken on the basis of this authorisation.

Client Signature: Signature of Witness:

Date: ____ / ____ / 20____

Date: ____ / ____ / 20____