Patient label:

Joint AOD Services Referral Form – Agency/Self-Referral

(Please complete all sections) **Date:** _____

Email completed form to Rata.AoDService@wcdhb.health.nz

Name: _____ Address: _____ _____ _____ _____	NHI: _____ Ethnicity: _____ DOB: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other _____ Medical Practice / GP: _____ _____
Telephone: Mobile _____ Home _____ Work _____ Email: _____	
Referral Source: ❑ Referrer has discussed AOD referral with patient, and they agree to referral being made. ☐ Self/Family/Whanau _____ (name) ☐ Justice/Police/Corrections (circle) ☐ GP: _____ (name) Practice: _____ ☐ NGO/Other Professional: _____ ☐ Other _____ (name) _____ (relationship)	
Suggested Priority: ☐ Urgent ☐ Semi-Urgent ☐ Routine	
Main Reason for Referral: (Please tick) ☐ Alcohol ☐ Cannabis ☐ Opiates ☐ Amphetamines ☐ Inhalants ☐ Hallucinogens ☐ Anxiolytics / Sedatives / Hypnotics ☐ Steroids ☐ Synthetics Other: ☐ Detox ☐ OST Programme	

_____

_____

_____

_____

How often consumed, and typical quantity per session?

Drug	Daily	Weekly	Less than weekly		Describe Withdrawal Symptoms	Weekly cost
Alcohol						$
Cannabis						$
Opiates						$
Amphetamines						$
Inhalants						$
Hallucinogens						$
Anxiolytics						$
Sedatives						$
Hypnotics						$
Steroids						$
Synthetics						$
Other						$

How much of a problem do feel you have? ☐ Nil ☐ Mild ☐ Moderate ☐ Severe

Is gambling an issue? ☐ No ☐ Yes - Cost per week $_____

Have you attended another AOD Service / OST Service / Residential Treatment? ☐ No ☐ Yes

Where _____ When _____

Where _____ When _____

Where _____ When _____

Have you attended a Mental Health Service in the past and/or been treated for any Mental Health issues by your GP?

☐ No ☐ Yes

Where _____ When _____

Where _____ When _____

Where _____ When _____

Are any Court Charges Pending? ☐ No ☐ Yes Date _____ Court _____

Details of Charges _____

_____

_____

_____

Patient Consent: I, _____ (write name) agree to this referral being made on my behalf for Alcohol and/or Other Drugs Assessment to determine suitability for appropriate addictions treatment.

I understand that this referral will be considered by a range of addictions treatment providers, and that this referral may be accepted by an addictions treatment service which may include Te Whatu Ora/Rata AOD Service, Salvation Army Bridge Programme, Pact, or Poutini Waiora.

Signature: _____ Date: _____

Staff to complete

Administration

Information given to Client or Agent: ❑ AOD Pamphlet

☐ Other _____ (specify)

☐ Triage Appointment _____ (date) Appointment Card Sent ☐

Clinician _____

Referral Meeting (Date) _____

Agencies Present ☐ Rata AOD/OST ☐ Pact ☐ Poutini Waiora ☐ Salvation Army

Referral Outcome: ☐ Rata AOD/OST ☐ Pact ☐ Poutini Waiora ☐ Salvation Army

☐ Declined.

If declined, give reason:

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this referral