

**METRO COMMUNITY ALCOHOL & DRUG SERVICE**  
**DRUG AND ALCOHOL YOUTH SERVICE**  
**FAX/EMAIL REFERRAL FORM**

Affix Consumer Label Here

**Referrer Details**

Contact Person: \_\_\_\_\_ Agency: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Consumer Details**

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M    F    O  
 Address: \_\_\_\_\_ Postcode: \_\_\_\_\_  
 Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Aboriginal/Torres Strait Islander:                      Yes    No                      CALD                      Yes    No  
 Permission to leave a voice/text message:              Yes    No                      Interpreter Required              Yes    No  
 Permission to send mail to address provided              Yes    No                      Language: \_\_\_\_\_  
 Permission to exchange information with GP/referrer/relevant agencies for purpose of treatment              Yes    No

**Parent / Guardian Details (if applicable)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Contact Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Does the young person live with a parent/guardian Yes    No    Is the parent/guardian aware of referral Yes    No  
 Has the young person given verbal permission to contact their parent/guardian Yes    No

**Reason for Referral / Drug Use History**

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CORRESPONDENCE

**Current Medical/Mental Health Problem(s) and Prescribed Medication(s)**

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**Additional Relevant Information**

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**Identified Risks and Safety Requirements**

History of Aggression/Violence:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Self-Harm/Suicidality:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Positive for BBV:	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Unsafe Injecting Practice:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Lives Alone:	<input type="checkbox"/> Yes <input type="checkbox"/> No

The consumer consented to the referral  Yes

Name of Referrer: \_\_\_\_\_ Referral Date: \_\_\_\_\_

**NORTH METRO COMMUNITY ALCOHOL & DRUG SERVICE**  
Joondalup Phone: (08) 9301 3200  
Warwick Phone: (08) 9246 6767

**NEXT STEP EAST METRO ALCOHOL & DRUG SERVICE**  
Phone: (08) 9219 1919

**SOUTH METRO COMMUNITY ALCOHOL & DRUG SERVICE**  
Fremantle Phone: (08) 9430 5966

**SOUTH EAST METRO COMMUNITY ALCOHOL & DRUG SERVICE**  
Thornlie Phone: (08) 9267 2400  
Armadale Phone: (08) 9399 5344

Rockingham Phone: (08) 9550 9200

**NORTHEAST METRO COMMUNITY ALCOHOL & DRUG SERVICE**  
Phone: (08) 9274 7055

Mandurah Phone: (08) 9581 4010

**DRUG & ALCOHOL YOUTH SERVICE** Phone:  
(08) 9222 6300

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