Western Health

ATTACH BRADMA HERE

DRUG HEALTH SERVICES
HOMELESS DUAL DIAGNOSIS
REFERRAL FORM
ADULT

WHDHS22

Family Name _____ Given Names _____

Preferred Name _____ Gender _____ Date of Birth __/__/__ Age ____

Address _____ Suburb _____

P/c _____ Contact Number/s _____

Aboriginal or Torres Strait Islander? ⎔**Y** ⎔**N** Main Language spoken at home_

Interpreter required **Y** ⎔ **N** ⎔ If so, which language _____

Medicare no: _____ **Expiry date:** _____

Does client/carer consent to referral? ☐ **Yes** ☐ **No**

Referrers Details

Name: _____ Name of Service _____

Phone _____ Fax No _____

Detail of GP/Psychiatrist/Mental Health Clinicians

Name: _____ Name of Service _____

Phone _____ Fax No _____

Name: _____ Name of Service _____

Phone _____ Fax No _____

Name: _____ Name of Service _____

Phone _____ Fax No _____

Depot Injection: Yes ⎔ No ⎔ Type: Date last given: / / Date due: / /

NEXT OF KIN OR CONTACT IN CASE OF EMERGENCY

Name _____ **Relationship to you** _____

Contact No _____ **Address** _____

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Reason for referral/expected outcome: ***(what is needing assessed, what type of recommendations are you seeking?)***

Current Psychiatric Diagnosis: ***(i.e.: Major Depressive disorder, Anxiety, Schizophrenia, Bipolar Disorder etc)***

Previous Psychiatric History: **(involvement with mental health services, hospitalisations, case management, private psychologist/psychiatrist?)**

Risk-taking behaviours: overdoses, blackouts, sharing equipment, using alone, poly-drug use, DUI, violence, self-harm

Medical History

Seizures/fits/epilepsy diagnosed? withdrawal related?, last seizure, frequency, medications past or present testing ( )

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Liver Disease hepatitis B/C, Cirrhosis, fatty liver, last liver function test? ( )_____

_____

_____

Head Injury Facial injuries, black eyes, accidents, violence, testing Outcomes ( )_____

_____

_____

Cardiac problems diagnosed heart problems, family history, hypertension, and medications/treatment ( )_____

_____

Chronic pain injury: symptoms, treatments, management ( )_____

_____

_____

Organic brain syndrome confusion, disorientation, disorganization: ( ) _____

_____

_____

Past alcohol and other drug treatment: (detox admissions, periods of counselling, residential rehabilitation ( )_____

_____

_____

Any Recent Hospital Admissions (Specify e.g. date, hospital, reasons for admission, length of stay, include ambulance attendances): _____

_____

_____

_____

_____

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Current Prescribed and other Medication (Including methadone, psychotropic medication, over-the counter drugs, complementary medicines e.g. herbs, vitamins, 'alternative' treatments

Medication	Prescribed Dose	Compliant Y/N)	Duration	Reason	Prescribing Doctor/Health Practitioner

Comments (regarding medication)_____

Substance				
Age of first use				
Age of first regular use				
Route of use				
Age first injected				
Average Daily Use I.e grams • **Alcohol:SD** • **Pills – No. &** Strength • **Powders:. Inj Per day**				
Days used in past 7 days	/7	/7	/7	/7
Days used in past 4 weeks	/28	/28	/28	/28
When last used				
Over what period of time has been using daily?				

Comments:_____

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DRUG HEALTH SERVICES
CONSENT TO TREATMENT AND
RELEASE OF INFORMATION

Youth ☐ Adult ☐ Forensic ☐

WHDHS22

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I, _____ (please print full name), DOB___/ _____/ ___

☐ Give consent to participate in treatment at Western Health Drug Health Services.

☐ I understand that information about me will be kept confidential unless permission is given by me to release information about my treatment. I understand that some programs operate within a shared care model with my General Practitioner:

The nominated relevant health professionals, services or people I wish to share information with are listed below:

_____

_____

_____

_____

_____

☐ I am aware of, and agree to the client rights and responsibilities as outlined in the Victorian Alcohol and Other Drug Client Charter.

Client or Authorised Representative:

Name:_____**Signature:**_____**Date:**_____

(Clients under 16 years may require parental or guardian consent).

Confirmation by Western Health, Drug Health Services staff member

I, ---------- have explained the rights and responsibilities of treatment at Western Health Drug Health Services In my opinion, he/she understood the explanation.

Name: _____ Signature:_____

Position: _____ Date:_____

Name of interpreter_____ Language_____

Organization : _____ Contact number_____