METRO COMMUNITY DRUG SERVICE
DRUG AND ALCOHOL YOUTH SERVICE

REFERRAL TO
NEXT STEP INPATIENT UNIT

Name: ……..

DOB:…….. / …….. / ……..

Tel No: (H)……..……..

(M)……..……

Aboriginal / Torres Strait Islander ☐ Yes ☐ No

CORRESPONDENCE

Client Address: …… Suburb: …… P/Code: ……

Gender: …… Country Of Birth: …… Preferred Language: ……

Referring Agency/Clinician: ……

Referrer Address: ……

Tel: …… Fax: …… Email: ……

Reason for referral: ……

……

Amount Used & Method of Use		Amount Used & Method of Use	
Alcohol	……	Marijuana	……
Opiates	……	Polysubstance use	……
Benzodiazepines	……	Ecstasy/LSD	……
Amphetamines	……	Solvents/inhalants	……

IVDU Status (tick) ☐ Yes: ☐ ≤ 3 months ago ☐ 3 ≤ 12 months ago ☐ 12+ months ago

☐ No: ☐ Never Injected

Tobacco…….

Current withdrawal/intoxication signs: ……

……

General medical history (Seizure history): ……

……

Current medications: ……

……

Relevant psychiatric history / Risk of self-harm: ……

……

Risk to others? Problem behaviour? Violence? ……

……

Other relevant information: ……

……

Follow-up arrangements – residential rehabilitation; counselling etc (if applicable): ……

……

Referrer Signature:…… . Date: …… / …… / ……

Fax to Inpatient Withdrawal Unit CNS: Fax:(08) 9219 1885 Tel:(08) 9219 1819

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Affix Client Label Here

CORRESPONDENCE