Queensland Government

Central Queensland Hospital and Health Service

Alcohol and Other Drugs Service (AODS)

External Referral

Facility / Unit: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

Rockhampton		**Yeppoon**		**Gladstone**	
Telephone	(07) 4920 5500	Telephone	(07) 4913 3224	Telephone	(07) 4976 3244
Fax	(07) 4927 9126	Fax	(07) 4939 3517	Fax	(07) 4976 3377
ATODS Rockhampton@health.qld.gov.au					

Rockhampton- Youth AODS (12-18 years)
Telephone (07) 4920 5700 Fax (07) 4920 5719 E-mail YouthAODSRockhampton@health.qld.gov.au

Engagement with AODS is voluntary and usually requires more than one visit.
Before making this referral, please consider:

(tick to acknowledge you have considered the below questions)
☐ **Has this client consented to AODS referral?**
☐ **Is this client willing to attend AODS for assistance with problematic substance use?**

***Date of Referral**	/ /

CLIENT DETAILS

***Surname:**	***First Name/s:**
***Date of Birth:**	**Sex:** ☐ Female ☐ Male ☐ Intergender
***Address:**	***Suburb:**
***Phone No:** Primary/Home……	*OK to leave message/SMS? ☐ Yes ☐ No
Work/Mob/Other ……	*OK to leave message/SMS? ☐ Yes ☐ No
***E-mail:**	

*Preferred contact method ☐ Mobile phone ☐ SMS ☐ Home phone ☐ Mail ☐ Other

Medicare Number: ID No: Exp: / /

ETHNICITY

Country of birth: Preferred language: Interpreter Required: ☐ Yes ☐ No

***Aboriginal or Torres Strait Islander or *Australian South Sea Islander Status:**

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Not Stated/Unknown

☐ Australian South Sea Islander Status ☐ Yes ☐ No

***SOURCE OF REFERRAL**

☐ Family member/friend	☐ Hospital	☐ HADS or Rehab	☐ School/Nurse/GO
☐ General Practitioner	☐ Mental Health	☐ Youth Justice	
☐ Other AODS Service	☐ Community Agency	☐ Court	☐ Other ……

***REQUEST FOR**

☐ Information	☐ Counselling	☐ Managed Withdrawal Support
☐ Assessment	☐ Rehabilitation	☐ Other……

PREVIOUS DRUG AND ALCOHOL TREATMENT (specify when mm/yyyy)

☐ None	☐ Rehabilitation ……
☐ AOD Counselling ……	☐ Drug Diversion Program ……
☐ Opioid Treatment Program ……	☐ Other ……

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AODS EXTERNAL REFERRAL

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RELEVANT MEDICAL HISTORY

☐ Yes	☐ No

If yes, please detail.

MENTAL HEALTH HISTORY (Diagnosis, Prescribed Medications and Risks)

☐ Yes	☐ No

If yes, please detail.

CURRENT SUBSTANCE USE (In particular this past 2 weeks)

Substance	Amount used/day	Frequency of use	Route	Date of last use	Length of time used

***REASON FOR REFERRAL / COMMENTS**

Referrer Name	
Agency/Organisation	
Contact Details (phone and/or email)	
Referrer Designation	
Signature	
Date	/ /