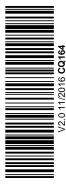
Queensland	(Affix identification label here)					
Government	URN:					
Central Queensland Hospi	Family name:					
	Given name(s):					
Alcohol and O	Address:					
Service (A	Phone:					
External Ro		Date of birth:	x: DMDFDI			
Rockhampton Telephone (07) 4920 5500 Fax (07) 4927 9126 ATODS Rockhampton@health.qld.	O7) 4913 3224					
Rockhampton- Youth AODS (12- Telephone (07) 4920 5700		7) 4920 5719	E-mail YouthAODS	Rockhampton@health.qld.gov.au		
Engagement with AODS is volumed Before making this referral, pleat (tick to acknowledge you have compared to the Has this client consented to the Is this client willing to attended.)	ase consider: onsidered the below questic AODS referral?	ons)				
*Date of Referral /	/					
CLIENT DETAILS		T				
*Surname:		*First Nam	ne/s:			
*Date of Birth:		Sex:	Sex:			
*Address:		*Suburb:	*Suburb:			
·	ne Other		ve message/SMS? ve message/SMS?	☐ Yes☐ No☐ Yes☐ No		
*E-mail:						
*Preferred contact method	☐ Mobile phone☐ Other	e ☐ SMS	☐ SMS ☐ Home phone ☐ Mail			
Medicare Number:	I	D No:	0 No: Exp: / /			
ETHNICITY						
Country of birth:	Preferred langua	age:	Interpreter Required: ☐ Yes ☐ No			
*Aboriginal or Torres Strait I	slander or *Australian S	outh Sea Islande	r Status:			
•	Strait Islander	_	☐ Not Stated/Unknow	'n		
☐ Australian South Sea Is	lander Status] No				
*SOURCE OF REFERRAL			20 . D. I. I			
☐ Family member/friend	☐ Hospital		OS or Rehab	☐ School/Nurse/GO		
☐ General Practitioner ☐ Other AODS Service	☐ Mental Health☐ Community Agency	☐ You	th Justice rt	☐ Other		
*REQUEST FOR						
☐ Information ☐ Assessment	☐ Counselling☐ Rehabilitation			/ithdrawal Support		
PREVIOUS DRUG AND ALCOHO	OL TREATMENT (specify wl	hen mm/yyyy)	<u>'</u>			
□ None		☐ Rehabi	litation			
☐ AOD Counselling	☐ Drug Di	☐ Drug Diversion Program				



☐ Opioid Treatment Program

☐ Other

	Queensland Government
--	---------------------------------

Ougandand	(Affix identification label here)									
Queensland Government			URN:							
Central Queensland Hospital a	nd Health Service	Family name:								
		Given name(s):								
Alcohol and Other Drugs		Address:								
Service (AODS) External Referral			Phone:							
	rai	Date of birth: Sex: \square M \square F \square I								
Facility / Unit:										
RELEVANT MEDICAL HISTORY										
☐ Yes			□No							
If yes, please detail.										
MENTAL HEALTH HISTORY (Diagno	sis, Prescribed Medicat	ions and F	Risks)							
☐ Yes			□No							
If yes, please detail.										
CURRENT SUBSTANCE USE (In par	tigular this past 2 wasks	\								
Substance	Amount		quency of	Route	Date	of last use	Length			
	used/day		use				of time used			
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
*REASON FOR REFERRAL / COMMI	ENTS									
Referrer Name	ENTS									
	ENTS									
Referrer Name	ENTS									
Referrer Name Agency/Organisation Contact Details	ENTS									
Referrer Name Agency/Organisation Contact Details (phone and/or email)	ENTS									
Referrer Name Agency/Organisation Contact Details (phone and/or email) Referrer Designation	ENTS									

Do not reproduce by photocopying All clinical forms creation and amendments must be conducted through Health Information Unit