AOD-Referral form

Date of Referral	

Person details

First name		**Last name**	
Nickname			
Date of birth		Age	
Address			
Postcode		**Mobile number**	
Language group			
Email			

Guardian/emergency contact details

First name		**Last name**	
Address			
Postcode		**Mobile number**	
Email			

Referral details

Source of referral	
Date of referral	
Contact details 1. **Name** 2. **Mobile** 3. **Email**	

About the person

Involvement with other services

Is the person of involved with Correction/ Justices/ Youth Justice?	Yes	No
Comments		

A client of child protection?	Yes	No
Comments		

Involved with Alcohol and Other Drugs program?	Yes	No
Comments		

Involved with Mental Health ?	**Yes**	**No**
Comments		
Involved with other services?	**Yes**	**No**
Contacts		

Living situation (cross one)

Lives with family		**Lives independently**	
Lives in some type of out of home care		**Does not have fixed address**	
Comments			

Education

Highest completed level of education		**Currently attending school/TAFE/Uni**	Yes	No
School name				

Employment

Currently employed?	Yes	No	**Length of employment (weeks)**	
Number of hours worked in past month			**If not currently employed, have you ever had a job?**	Yes / No

Interest and hobbies	

Is the person experiencing any illness at the moment?	**Yes**	**No**
If yes: - **Type of illness** - **How long you have had this illness** - **What you have been told about how long it might last** - **What treatment you are seeking**		

If under age: permission to contact Young Person – YES / NO

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Patrick Hynes: 0418 942 684
Email:

(Thursdays & Fridays)

_____	_____	_____
Referrer name	**referrer signature**	**Date Allocated**