

## Connected Recovery Referral Form

### Private and Confidential

#### Client Consent and Privacy

All services and supports provided by CatholicCare are voluntary. Please confirm that you have client consent for this referral by placing a tick in the relevant box. All information is handled in accordance with our privacy policy.

Written Consent       Verbal Consent       N/A – Self Referral

#### Client Personal Details

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Gender:  Male       Female       Other (please specify) \_\_\_\_\_

Does the person identify as indigenous?  Yes       No

If Yes,  Aboriginal       Torres Strait Islander       Both

Country of Birth \_\_\_\_\_ Preferred Language \_\_\_\_\_

Translator required  Yes       No

Please provide details of how the client wishes to be contacted by CatholicCare to arrange an appointment - you may place a cross in multiple boxes

Phone # \_\_\_\_\_ Can we leave a message on this phone?  Yes       No

Most convenient time to call \_\_\_\_\_ If mobile, can we send an SMS?  Yes       No

Email \_\_\_\_\_  Letter to home address

Letter to alternate address (provide details) \_\_\_\_\_

**Location of Services Required** – you may place a cross in multiple boxes

Taree       Forster       Gloucester

**Is the person being referred a current NDIS participant?**

Yes

No

**Reason for Referral**

**Presenting Mental Health Issue** e.g. Diagnosis, issue - anxiety, depression, etc.

**Drug and/or Alcohol Issue** e.g. alcohol, cannabis

**Other Health Issues or Psychosocial Factors** E.g. medical factors, other diagnosis, homelessness, stress, social situation

**Risk Factors** e.g. Harm to self or others, suicide risk, vulnerability

**Other relevant information and current services involved**

**Person Making Referral**

Name	_____	Date of Referral	_____
Organisation	_____		
Phone	_____	Fax	_____
		Email	_____

Please email referral to:

[connectedrecovery@catholiccare.org.au](mailto:connectedrecovery@catholiccare.org.au)