



**APY LANDS REFERRAL FORM**

DASSA USE ONLY

**THIS SECTION TO BE COMPLETED BY THE REFERRING AGENCY**

CRN:

**EMAIL: HealthDASSAAPY@sa.gov.au**

<b>1. SURNAME</b>	
<b>2. GIVEN NAME(S)</b>	
<b>3. DATE OF BIRTH</b>	Estimated age
<b>4. SEX</b>	
<b>5. DATE OF REFERRAL</b>	
<b>6. PREFERRED LANGUAGE</b>	
<b>7. COMMUNITY</b>	
<b>CLIENT ADDRESS</b>	<b>GENERAL PRACTITIONER DETAILS</b>
<b>Phone Number</b>	<b>NAME</b>
	<b>ADDRESS</b>
	<b>Phone Number</b>
<b>8. Known details of AOD use (tick all relevant issues)</b>	<b>Specify:</b>
<u>Issues of Concern</u>	
01 Alcohol	01
02 Tobacco	02
03 Cannabis	03
04 Opiates	04
05 Amphetamines	05
06 Benzodiazepines	06
07 Other (specify)	07
08 Mental Health	08
09 Physical Health	09
10 Accommodation	10
11 Other (financial, disability, Legal Issues, DV)	11
12 Family/Significant Other	12
13 Petrol	13
14 Ex Petrol	14
15 Solvents	15
16 Not Stated	16
17 Not Applicable	17
<b>9. HAS THE PERSON REFERRED TO DASSA CONSENTED TO THIS REFERRAL?</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
<b>10. IS THIS A MANDATED REFERRAL TO DASSA? (If yes please attach court/agency mandate)</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
<b>11. HAS THE PERSON BEING REFERRED CONSENTED TO DASSA LOCATING HIM/HER</b>	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
<b>12. DO YOU REQUIRE FEEDBACK FROM DASSA?</b>	Yes 01 <input type="checkbox"/> No 02 <input type="checkbox"/> Written Yes 01 <input type="checkbox"/> No 02 <input type="checkbox"/> E-Mail Yes 01 <input type="checkbox"/> No 02 <input type="checkbox"/>
<b>13. REFERRING AGENCY</b>	
<b>14. REFERRING PERSON</b>	
<b>POSITION/TITLE</b>	
<b>15. REFERRING PERSONS CONTACT DETAILS</b>	
<b>Phone Number</b>	<b>Fax Number</b>
<b>E-Mail</b>	<b>Address</b>