Fresh Start Self/Carer Referral Form

CLIENT NAME: _____

Referral from: ☐ Carer ☐ Self-Referral

Reason for Referral:
……
……
……

Current Medications: (Attach separate sheet if necessary)

Medication	**Dosage**	**Medication**	**Dosage**

Allergies:……

Covid19 vaccinations received (tick all that apply): ☐ Dose 1 ☐ Dose 2 ☐ Booster ☐ None

Substances Used (please tick)

☐ Alcohol ☐ Amphetamines ☐ Opiates ☐ Cannabis ☐ Benzodiazepines

☐ Suboxone/Subutex ☐ Methadone ☐ Tobacco ☐ Other (please list) _____

DATE	**COMPLETED BY**	**ALLERGY ALERT**
CLIENT DETAILS		
Name: _____		
Date of Birth: _____/____/_____ **Contact Number(s)**:_____		

Address:_____

Email:_____

Preferred contact method: : ☐ Email ☐ Phone

Occupation:_____

Medicare no._____**Exp:**_____ **CRN**_____**Exp:**_____

Nationality:_____ **Australian Citizen:** ☐ Yes ☐ No

If no, visa type:_____ Exp date_____

Do you identify as Aboriginal or Torres Strait Islander: ☐ Yes ☐ No
Do you require an interpreter? ☐ Yes ☐ No

Religion:_____

NEXT OF KIN / CONSENT TO RELEASE INFORMATION

NOK 1:
Name:_____
Relationship:_____
Contact number:_____

NOK 2 *(if applicable):*
Name_____
Relationship:_____
Contact number:_____

Other contacts (*if applicable)* e.g lawyer/corrections officer
Name:_____
Occupation:_____
Contact number:_____

Name:_____
Occupation:_____
Contact number:_____

I give permission for Fresh Start Staff to share information to my next of kin and other contacts in regards to my recovery. I understand that if I wish to change my next of kin I must do so in writing. Fresh Start staff will not share information with anyone else unless given permission.

Client Name:_____ **Witness Name**:_____

Signed: _____ Signed: _____

Date:_____ Date:_____

Send this form to the Clinical Coordinator, Subiaco

Tel: (08) 9381 1333

Email: info@freshstart.org.au