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Supporting Youth and Families Towards a Better Future

Allocation Referral Form

Offices located at: Devonport and Burnie

Name of Client: ________________________________ D.O.B. ___________/Age________

Address: ____ Phone _______________

Gender: Male / Female /other Ethnicity: ____________________

Substance/s *most* problematic: ____________________ 1. Own use. 2. Other's drug use (please indicate)

Preferred counsellor □ Male □ Female (only if possible)

Treatment delivery setting □ Office □ Home outreach □ Outreach area: __________________

Have you received support from this service before? Yes / No **(If yes, worker's name________________)**

Comorbidity Issues Yes/No (ie diagnosed illness, eg depression) Please specify ____________________

Comments:____

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Referring Agency_________________________ Name of worker:____________________

Phone____________________ Fax_______________________

Please feel free to attach any further information regarding this referral

CONSENT TO RELEASE INFORMATION

I,_____________________________ consent to:___________________________ of ____________________ releasing information regarding myself to: ***Youth, Family and Community Connections Inc.***

I understand that this consent will expire 12 months from the date of signing or on the termination of my contact with Youth, Family and Community Connections Inc., whichever occurs first. I understand that I may withdraw this authorisation, in writing, at anytime prior to the expiry date, except where action has already been taken on the basis of this authorisation.

Signature of client______________________ Signature of worker____________________

Date: ………/………./………. Date………/………./……….