



# SPRINGBOARD

## Alcohol and Other Drugs Program Referral Form

### Referred Person Details

Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address \_\_\_\_\_ Postcode \_\_\_\_\_  
Phone number \_\_\_\_\_ Email \_\_\_\_\_

Has the person been informed of, or participated in and agreed to this Springboard referral? Yes  No

### Alcohol and Drug Screening

Primary drug \_\_\_\_\_ Primary method of use \_\_\_\_\_

- Other substances**
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol           | <input type="checkbox"/> Amphetamines   | <input type="checkbox"/> Benzodiazepine    |
| <input type="checkbox"/> Barbiturates      | <input type="checkbox"/> Cannabis       | <input type="checkbox"/> Cocaine           |
| <input type="checkbox"/> LSD               | <input type="checkbox"/> MDMA (Ecstasy) | <input type="checkbox"/> Heroin            |
| <input type="checkbox"/> Opioid Analgesics | <input type="checkbox"/> Other          | <input type="checkbox"/> Methadone         |
|  | <input type="checkbox"/> Stimulants     | <input type="checkbox"/> Nicotine          |
|  |   | <input type="checkbox"/> Volatile Solvents |

Date last used: \_\_\_\_\_

### Other Details

#### Mental & Intellectual Health Information (History/Symptoms/Diagnosis/Treatment)

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#### Physical Health Information (History/Symptoms/Diagnosis/Treatment)

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#### Duty of Care and OH&S Issues (Risk of harm to self and/or others)

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#### Existing Supports (Services/Family/Friends/Self-Help Groups)

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Referrer name		Referring service	
Contact details		Date	

## Guide for answering 'Other Details'

The following questions are a guide for the type of information that we are seeking in the 'Other Details' section of the referral. You do not need to provide answers to all of the following questions. This is designed to support your professional wisdom around the referral for Springboard.

### **Mental & Intellectual Health Information** (History/Symptoms/Diagnosis/Treatment)

- *Has the referred person been formally diagnosed with a mental illness?*
- *Did their mental health concerns precede their substance use?*
- *How does their mental health present to you?*
- *Do they take any medication?*
- *Do they have any behavioural management plans or strategies?*
- *Have they received any psycho-education around the nature of their mental health presentation?*
- *Does the referred person have any learning difficulties?*
- *Do they have an acquired brain injury?*
- *Do they need any additional support in a learning environment?*

### **Physical Health Information** (History/Symptoms/Diagnosis/Treatment)

- *Is the referred person physically active?*
- *Are there any limitations in doing physical exercise?*
- *Have they been able to eat regularly recently?*
- *Are they looking after their personal hygiene?*

### **Duty of Care and OH&S Issues** (Risk of harm to self and/or others)

- *Does the referred person have a history of self-harm? In the last year?*
- *Do they have a history of suicidal ideation? In the last year?*
- *Have they ever attempted suicide? In the last year?*
- *Do they have a history of verbal or physical abuse towards others?*

### **Existing Supports** (Services/Family/Friends/Self-Help Groups)

- *Does the referred person have a doctor they see regularly?*
- *Do they have a mental health professional they see regularly?*
- *Are they receiving case management?*
- *Do they have family, friend or other social networks to support them?*

Please email form to: [springboard@communify.org.au](mailto:springboard@communify.org.au) or call: 07 3308 4513