DEADLY CONNECTIONS
COMMUNITY AND JUSTICE SERVICES

GIRRA GIRRA PLACE REFERRAL FORM

***Please note this referral will not be considered unless all sections are completed, including page 4 consent to exchange information

SECTION ONE – REFERRAL SOURCE

Date of referral:	**Name of referrer:**
Agency:	
Position:	**Phone:**
Email:	
IS THERE A WILLINGNESS TO LIVE IN A RESIDENTIAL THERAPEUTIC SETTING FOR A MINIMUM OF 3 MTHS? ☐ YES ☐ NO	
ANYONE ENTERING GIRRA GIRRA PLACE WILL NEED TO BE DRUG FREE FOR 5 DAYS PRIOR TO ENTRY ☐ YES ☐ NO (AGREE)	
RECEIVING OR ELIGIBLE FOR CENTRELINK?: ☐ YES ☐ NO **CRN**	
PLEASE CONFIRM PROGRAM HAS BEEN EXPLAINED TO CLIENT and CONSENT TO REFER HAS BEEN GIVEN BY CLIENT: ☐ YES ☐ NO	
IMPACTED BY ☐ SUBSTANCE MISUSE ☐ HOMELESSNESS ☐ INCARCERATION ☐ CHILD PROTECTION ☐ VIOLENCE ☐ TRAUMA	

SECTION TWO – PARTICIPANT INFORMATION

Name:	**D.O.B / /**
Cultural Identity:	**Gender ☐ Male ☐ Female ☐ or (please insert gender)**
Address:	**Phone:**
Reason for referral:	

SECTION THREE – CHILDREN (JARGUMS) INFORMATION

Full name of child	Age	Gender	Care status	Address

Pregnant? ☐ Yes ☐ No provide details

Current or previous involvement with DOCS? ☐ Yes ☐ No provide details

DOCS caseworker/office/contact:

SECTION FOUR – HEALTH & DISABILITY

Principal drug of concern?

Method of use? ☐ Ingest (drink) ☐ Smoke ☐ Inject ☐ Sniff (powder) ☐ Inhale (vapour) ☐ Other

Other drugs of concern?

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Injecting drug use? ☐ Injected < 3 mths ago ☐ Injected 3-12 mths ago ☐ Injected > 12 mths ago ☐ Never injected

Are you on Opioid pharmacotherapy? ☐ Yes ☐ No ☐ Methadone ☐ Buprenorphine ☐ Suboxone
current dose: date commenced: date of last dose:
Dose and attendance stable: ☐ Yes ☐ No if no provide details:

Any immediate and/or ongoing physical health and/or physical disability challenges? ☐ Yes ☐ No provide details e.g. liver damage, heart or lung disease, diabetes, chronic pain, recent injuries etc

Taking any medication or receiving any treatment for the above physical health and/or disability concerns? ☐ Yes ☐ No provide details

Immediate and/or ongoing mental health concerns? ☐ Yes ☐ No provide details e.g depression, anxiety, delusional or paranoid thoughts

Taking any medication or receiving any treatment for the above MH concerns? ☐ Yes ☐ No provide details incl. treatment, medication proscribed (types & dosages) and levels of compliance

Any previous admissions for identified MH concerns or others not listed here? ☐ Yes ☐ No provide details of all admissions, length of stay & treatment received – request hospital discharge summary

Immediate and/or ongoing cognitive or intellectual disabilities or impairments? ☐ Yes ☐ No provide details ABI, dyslexia, learning difficulties etc

Receiving any treatment or supports for the identified challenges above? ☐ Yes ☐ No provide details

Are you fully vaccinated? ☐ Yes ☐ No First dose? ☐ Yes ☐ No Are you willing to be vaccinated? ☐ Yes ☐ No

SECTION FIVE – JUSTICE INFORMATION

Do you have previous or current justice involvement? ☐ Yes ☐ No provide details incl. period of incarceration, nature of offending, most recent offence etc

Any outstanding matters or warrants? ☐ Yes ☐ No provide details

Currently in: ☐ Community ☐ Custody Location: **MIN:**

☐Sentenced ☐ Remand expected date of release:

Seeking Bail ☐ Yes ☐ No

Community based order: ☐ Yes ☐ No **Type of Order:**	**Community Corrections/JJ Office:** **Officer:**

Bail Conditions (if applicable):

Lawyers details:

SECTION SIX – RISK FACTORS

Does anybody have an ADVO against you? ☐ YES ☐ NO If yes, please provide details:
Do you have an ADVO out against anybody? ☐ YES ☐ NO If yes, please provide details:
Are there any other risks we should be aware of? (e.g. risks to staff, other residents or the community) **☐ YES ☐ NO If yes, please provide details:**

SECTION SEVEN – OTHER INFORMATION

OFFICE USE ONLY – Intake outcome	
Client rating ☐ Urgent ☐ High ☐ Medium ☐ Low	**Date & Time:**
Previous client ☐ Yes ☐ No Meets Eligibilty Criteria ☐ Yes ☐ No	
Progress to assessment phase ☐ Yes ☐ No Allocated to: ☐ Follow up to Referrer to advise of outcome ☐ Nominated person notified and given further information/advice	**Date & Time:**
Not progressing to assessment phase ☐ Yes ☐ No Why? ***Follow up actions (please select one)*** ☐ Follow up to Referrer to advise of outcome ☐ Nominated person notified and given further information/advice	
Further information required: If yes, please provide details: **☐ authority to exchange information ☐ criminal history ☐ hospital discharge summary** **Other:**	
Plan for progression to assessment phase;	
Notes:	

*****Please note: completion of this form does not indicate acceptance of referral and placement on program/s**
Completed form to be returned to referrals@deadlyconnections.org.au

DEADLY CONNECTIONS
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AUTHORITY TO ACT & CONSENT TO EXCHANGE INFORMATION

By signing this form, you authorise the staff, volunteers, student placements and management of Deadly Connections to act on your behalf by exchanging relevant information with other services.

The authorised person(s) as designated above may share necessary personal details with various services in order to effectively advocate, refer or support you. This will be discussed with you prior to any information being released. When you appoint your authorised person to act on your behalf, we may:

- Deal with the relevant services as though we are you
- Engage external agencies or representatives to act and advocate on your behalf
- Obtain or release information required to provide the best possible support to you/your children and to address your needs.

You can change or cancel this authority at any time by contacting Deadly Connections or nominating a cancellation date.

AUTHORISATION

I, _____(name) of

_____ (address)

Authorise Deadly Connections to act on my behalf in relation to matters concerning:

_____

_____

until _____ (specify date if required).

Signed _____ Date _____

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