



AOD Wellbeing Berri Client Referral Form

Please ensure all fields are entered correctly with appropriate information

Checklist

Does the client meet the Criteria?

- 18 years or older
- Current significant harmful alcohol and/or drug use
- Not a risk of harm to self or others
- No history of sexual assaults
- Voluntary and wanting to change
- No monitoring devices

Name of Person being Referred: _____

DOB: _____ **Age:** _____ Male Female LGBTIQ+

Does this person identify as Aboriginal or Torres Strait Islander? Yes. No

Does this person identify as Culturally and Linguistically Diverse? Yes. No

Is this person – Homeless/Couch Surfing **Home Detention** **Renting**

Incarcerated **NFA**

Address _____

State _____ **Post Code** _____

Phone Number _____ **Alternative Phone Number** _____

Email Address: _____

Medicare Number: _____ **Reference number:** _____ **Expiry:** _____

Centrelink Reference Number (CRN): _____ **Expiry:** _____

Have they been to AOD Wellbeing Berri before? Yes No

Have you been vaccinated for COVID-19? Yes No

If “Yes”, Which vaccination dose have you received to date? 1st 2nd 3rd 4th

If “No”, Would you consider being vaccinated against COVID-19 prior to coming to AOD Wellbeing Berri?

Yes No

Please provide a copy of your COVID-19 Vaccination Certificate with this referral

Do you have “My Health Record” setup on MyGov? Yes No

If “No”, Would you consider activating this on your MyGov Account? Yes No

Have you been referred other rehabilitation services? Yes. No

If “Yes”, Where have you been referred? _____

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ABORIGINAL
DRUG & ALCOHOL COUNCIL (SA)
ABORIGINAL CORPORATION

Current Drug use:

Drugs used	What is the type of Drug /Alcohol you use?	How much do you use?	How do you use? (IV/Smoke/Drink/etc.)	How often do you use	When did you last use?	Have you used drugs or drunk like this for a year?	Age of First Use
Alcohol							
Amphetamines							
Cannabis							
Benzodiazepines							
Inhalants							
Opioids							
Other Drugs (includes non-prescription)							
Tobacco							

Height: _____ Current Weight: _____

Reason for Referral _____

Name of Referrer: _____ Position: _____

Organisation: _____

Phone Number: _____ Email: _____

Signature of Referrer _____ Date of Referral _____

Referral forms can be emailed to riverland@adac.org.au

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