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Referral Form - Therapeutic Community
Hope Community Services

Related policy: Service Delivery - Referral Policy (SDP05)

Referrer details

Title: Dr Mr Ms First name _____ Last name _____

Phone _____ Fax _____ Mobile _____

Email _____

Client's details

First name _____ Last name _____

Date of birth _____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Aboriginal / Torres Strait Islander ☐ Australian, not indigenous ☐ Other

Is the client aware of this referral? ☐ Yes ☐ No

Client consents for HOPE and referrer to exchange information? ☐ Yes ☐ No

Client's contact details

Address _____ Town/suburb _____ Postcode _____

Phone _____ Mobile _____

Client's emergency contact / support person / next of kin

First name _____ Last name _____

Address _____ Town/suburb _____ Postcode _____

Phone _____ Mobile _____ Email _____

Brief history (Physical & mental health, legal, etc):

_____

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Referral Form - Therapeutic Community
Hope Community Services

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Drugs of Concern: Alcohol ☐ Benzodiazepines ☐ Cannabis ☐ Methamphetamine ☐

Other (please specify): _____

Withdrawal / detox plan: _____

Other relevant information: _____

Please email the completed referral to rhreception@hopecs.org.au

Or call Rosella House on 9921 7409 to discuss.