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| **Odyssey Community Services**  **65 Alive Referral Form**  Seniors AOD Service | | | | | | | | |
| **NB Please complete this form in full and email or fax or post** | | | | | | | | |
| **Date:** |  | | **Name:** |  | | | | |
| **NHI:** |  | | **DOB:** |  | | **Ethnicity:** | |  |
| **Gender:** |  | | **Address:** |  | | | | |
| **Phone number:** | | **Hm: Mb:** | | | | | | |
| **Name of GP:** | |  | | | | | | |
| **Medical Centre:** | |  | | | | | | |
| **Does the individual consent to this referral being made to 65 Alive? Please Circle: YES / NO** | | | | | | | | |
| **Does the individual consent to the service contacting their GP? Please Circle: YES / NO** | | | | | | | | |
| **Referrers Name** | |  | | | **Agency (if applicable):** | |  | |
| **Referrer’s Phone** | |  | | | **Referrers Fax Number:** | |  | |
| **Referrers Address:** | |  | | | **Referrer’s email:** | |  | |

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| **REASONS FOR REFERRAL AND ANY PERTINENT INFORMATION** (current and past substance use, previous AOD assessments, any known mental health service involvement, client’s hopes, any known risk issues, any disabilities, other agencies involved, Family/other supports): |
|  |
| **MEDICAL PROBLEMS** |
|  |
| **CURRENT MEDINCATIONS** |
|  |
| **Are there any barriers to the client attending the service (eg work, transport, motivation)?** |
|  |
| **Any known risk issues** |
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