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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): |
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| **MEDICAL PROBLEMS** |
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| **CURRENT MEDINCATIONS** |
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| **Are there any barriers to the client attending the service (eg work, transport, motivation)?** |
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| **Any known risk issues** |
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