Council for Aboriginal Alcohol Program Services
Aboriginal Corporation

Referral Form

Please complete and return to CAAPS;

Email: intake@caaps.org.au

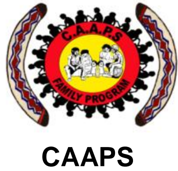
Fax: 08 89224837

Assessment
The preferred method of assessment is in person onsite Phone assessments will be conducted only if; the client is out of the Darwin area the client is incarcerated

Intake
CAAPS Healthy Family intake panel will assess the clients suitability to enter program and advise of entry date if suitable. If client is found not suitable CAAPS will assist in referrals to other services if required.

Referral Form

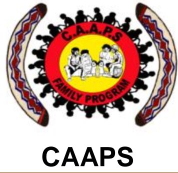
Instructions for completion by referrers and other agencies; please complete the form in the client's presence to ensure the client and referrer have discussed the referral and that it is the clients preferred option. Ensure all the questions are answered honestly and to the best of your knowledge.



Council for Aboriginal Alcohol Program Services Aboriginal Corporation

Referral Information - *Please use black pen.* (To be completed by person making referral together with the client)			
Name of Referrer			
Organisation		**Contact No**	

Personal Details			
Name			
Other Names			
Date of birth		**Interpreter needed**	Yes/No
Medicare Number		**Language spoken**	
Centrelink Number		**Please attach current Centrelink summary**	
Ethnicity – *Please circle*			
Aboriginal	Torres Strait Islander	Aboriginal and Torres Strait Islander	Other
Gender	Male	Female	Other
Current Address			
			P/C
Home community		**How long Since you lived there?**	
Phone/ Mobile number			
Contact person in case of emergency			
Name		**Relationship to you**	
Address			
Phone No			**P/C**



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Relationship and names of other family members who you want to enter the program with you					
Name		**Relationship**		**Age**	
Name		**Relationship**		**Age**	
Name		**Relationship**		**Age**	
Name		**Relationship**		**Age**	
Name		**Relationship**		**Age**	

I confirm that I have completed this form in the presence of the client and that I have ensured the client fully understands the purpose and nature of this referral (confirm use of Aboriginal Interpreter Services (89998353) if not proficient in English)			
Referrer		Yes	No
Name of referrer PRINT			
Signature of referrer		**Date**	
Name of client PRINT			
Signature of client		Date	

Council for Aboriginal Alcohol Program Services Aboriginal Corporation

Release of Information

I, __________________________, hereby authorize and request _____________ ____________________________to supply the required information concerning myself to:

Organisation: Council for Aboriginal Alcohol Program Services Inc.

Address: 60 Boulter Road, Berrimah NT 0820
PMB 22 Berrimah NT 0822

Client's Name: ____________________

Signature _________________

Date __/__/__

Witness Name:_________________________

Position: ______________________________

Organisation: ___________________________

Date __/__/__