**Referral to Sunrise Centre**

*Please use this form to make referrals to Sunrise Centre*

|  |  |
| --- | --- |
| Date |  |

***Program Information***

|  |  |
| --- | --- |
| Which program are you referring too? | Homelessness Program  Alcohol & Other Drugs – Rehabilitation program |
| Reason for referral |  |

***Referring agency or professional***

|  |  |  |  |
| --- | --- | --- | --- |
| Agency |  | | |
| Contact person |  | Position |  |
| Phone |  | Fax |  |
| Email |  | | |
| Would you continue to be involved if this referral is accepted? 0 Yes 0 No | Yes  No  If yes in what capacity? | | |

***Client Details***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | Phone | | |  |
| Address |  | | | | | | | |
| Gender | Male  Female  Other | | | | DOB | | |  |
| Country of birth | | |  | | | | Do you identify as Aboriginal or Torres Strait Islander?  Yes  No | |
| Requires interpreter | | Yes  No | | Language | |  | | |
| Income | | Centrelink  Employed  Unemployed  Other       Next payment date | | | | | | |
| Medical/Disability needs | | Hearing  Learning  Mobility  Vision  Medical  Other | | | | | | |
| Current situation of client including risks and safety concerns? | |  | | | | | | |
| Is there are current Mental Health Care plan | | Yes  No | | | | | | |
| ***Additional Information/Attachments*** *– please provide relevant information to support the referral, eg medical information, type of addiction, legal issues,etc* | | | | | | | | |
|  | | | | | | | | |
| Emergency Exit Plan: | |  | | | | | | |

***Other services engaged with the client:***

|  |  |  |  |
| --- | --- | --- | --- |
| Agency |  | | |
| Contact person |  | Phone |  |
| Agency |  | | |
| Contact person |  | Phone |  |
| Agency |  | | |
| Contact person |  | Phone |  |

**Self-Completion Form**

*This section is to be completed by the Client. This form is to be submitted with the Sunrise Centre referral form.*

AUDIT: The following questions will give us a picture of your recent alcohol use, and will help us determine how best to help you. Please circle the response that best describes your drinking. If you haven’t been drinking alcohol you don’t need to answer the questions.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 0 | 1 | 2 | 3 | 4 |
| **1** | How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| **2** | How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| **3** | How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **4** | How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **5** | How often during the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **6** | How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **7** | How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **8** | How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **9** | Have you or someone else been injured because of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |
| **10** | Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |

DUDIT: The next questions will help us to understand whether use of all drugs other than alcohol is a problem for you. This *includes* illicit drugs & pharmaceutical medications (e.g. sleeping pills, pain killers). It does *not include* medication that you take as *prescribed* by your doctor. Please circle the response that best describes your use of all drugs (other than alcohol). If you haven’t been using any, then you don’t need to answer the questions.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 0 | 1 | 2 | 3 | 4 |
| **1** | How often do you use drugs other than alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| **2** | How often do you use more than one drug on the same occasion? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| **3** | How many times do you take drugs on a typical day when you use drugs? | 0 | 1 or 2 | 3 or 4 | 5 or 6 | 7 or more |
| **4** | How often are you influenced heavily by drugs? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **5** | Over the past year, have you felt your longing for drugs was so strong that you could not resist it? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **6** | Has it happened, over the past year, that you have not been able to stop taking drugs once you started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **7** | How often over the past year have you taken drugs and then neglected to do something you should have done? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **8** | How often over the past year have you needed to take a drug the morning after heavy drug use the day before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **9** | How often over the past year have you had guilt feelings or a bad conscience because you used drugs? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **10** | Have you or anyone else been hurt (mentally or physically) because you used drugs? | No |  | Yes, but not in the last year |  | Yes, during the last year |
| **11** | Has a relative or a friend, a doctor or a nurse, or anyone else been worried about your drug use or said to you that you should stop using drugs? | No |  | Yes, but not in the last year |  | Yes, during the last year |

K10: The following questions ask about how you have been feeling during the past 30 days. It’s important to understand how you are feeling and where you are at. For each question, tick the box that best describes how often you had this feeling.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DURING THE PAST 30 DAYS, HOW OFTEN DID YOU FEEL** | | NONE OF THE TIME 1 | A LITTLE OF THE TIME  2 | SOME OF THE TIME 3 | MOST OF THE TIME 4 | ALL OF THE TIME  5 |
| **1** | **...tired for no good reason?** |  |  |  |  |  |
| **2** | **...nervous?** |  |  |  |  |  |
| **3** | **...so nervous that nothing could calm you down?** |  |  |  |  |  |
| **4** | **...hopeless?** |  |  |  |  |  |
| **5** | **...restless or fidgety?** |  |  |  |  |  |
| **6** | **...so restless that you could not sit still?** |  |  |  |  |  |
| **7** | **...depressed?** |  |  |  |  |  |
| **8** | **...so depressed that nothing could cheer you up?** |  |  |  |  |  |
| **9** | **...that everything was an effort?** |  |  |  |  |  |
| **10** | **...worthless?** |  |  |  |  |  |

***Client Consent*** *(referrals cannot be processes unless client has provided their consent)*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent for a referral to be made on mybehalf to The Salvation Army Sunrise Centre and for my personal information, required for the purposes of this referral, to be provided the Sunrise Centre.

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature |  | Date |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Sunrise Office Use only*** | | | | |
| ***Intake Officer*** *to complete:* | | | | |
| *Date Received* |  | *Date Contacted* | |  |
| *Assessment Location* |  | *Assessment Worker Name* | |  |
| *Date Intake Meeting* |  | *SAMIS Completed* | *Yes  No* | |
| *Case Manager allocated* |  | *SAMIS Code* |  | |

***Notes***

|  |
| --- |
|  |