**Referral to MTC**

*Please use this form to make referrals to the MTC - AOD Rehabilitation.*

***Please attach consent to release personal information.***

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

***Referring agency or professional***

|  |  |
| --- | --- |
| Agency |       |
| Contact person |       | Position |       |
| Phone |       | Fax |       |
| Email |       |

***Client Details***

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Phone |       |
| Address |       |
| Gender | [ ]  Male [ ]  Female [ ]  Transgender | DOB |       |
| Country of birth |       | [ ]  Aboriginal [ ]  Torres Strait Islander |
| Requires interpreter | [ ]  Yes [ ]  No | Language |       |

***Your Relationship to Client***

**[ ]** Relative, friend or support person **[ ]** Doctor **/** Health Care Professional

**[ ]** Legal Representative **[ ]** Case manager / Counselor

**[ ]** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Additional Information*** *(include any other relevant information to support the referral, eg medical information, type of addiction, legal issues, etc.*

|  |
| --- |
|       |

***Do you know of any other services involved with this person?***

|  |
| --- |
|       |

*Would you continue to be involved if this referral is accepted?* **[ ]** Yes **[ ]** No

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

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent for a referral to be made on my

 *(Client Name)*

behalf to The Salvation Army MTC program and for personal my personal information, required for the purposes of this referral, to be provided the MTC program.

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