**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 |  |