**FYRST South West**
Headspace Liverpool
50 Macquarie St, Liverpool NSW 2170
Ph: (02) 8785 3200
Fax: (02) 8568 7932
PO Box 324 Doonside 2767

Mobile:0408 242 685
Mobile:0427 022 052
Email: fyrst.southwest@salvationarmy.org.au

Youthlink fyrst
AOD Support Program

**FYRST West**
Shop 3, 254 Beames Ave,
Mt Druitt, NSW, 2770
Ph: (02) 9832 3934
Fax: (02) 9832 3708
PO Box 324 Doonside 2767

Mobile: 0401 005 186
Mobile: 0439 340 861
Email: fyrst.west@salvationarmy.org.au

# AGENCY REFERRAL FORM

**Client Name:** _____ **DOB:** _____

**Address:** _____

**Contact number:** _____ **Gender:** _____

**Client email address**: _____

**Language spoken at home:** _____ **Ethnicity:** _____

**Interpreter required:** *Yes* ☐ *No* ☐

**Next of Kin or Emergency Contact *(name and number):*** _____

## AOD (Alcohol and Other Drugs)

**Current AOD use:** _____

_____

**Previous AOD use:** _____

_____

## Mental Health

**Does the client have Mental Health concerns?** *If so, please give details:*_____

_____

_____

**Is the young person receiving support for Mental Health concerns?** *If so, please give details:* _____

_____

_____

**Does the client have a disability?** *If so, please give details:* _____

_____

_____

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**Are there any risks or concerns identified with the client?** _____

_____

**Other support: is the young person receiving support from another service?** *If so please give details*:

_____

_____

**Possible case management needs or assistance required:** *Please tick & provide further details if necessary*

AOD intervention ☐ _____

Housing/Accommodation ☐ _____

Education/Training or Employment ☐ _____

Legal Support ☐ _____

Other ☐ _____

**FYRST SELECTION CRITERIA**

- The young person is aged between 12 and 25 years, and has a current or prior history of substance use
- The young person lives within Sydney's South West, or Greater West LGAs or willing to commute to these offices if outside these LGAs.
- The young person does not need immediate care for an acute psychiatric or physical illness
- The young person consents to see FYRST staff, and be voluntarily involved with the FYRST program
- The young person must be willing to enter into case management and address drug & alcohol issues, or case management issues including assistance with housing options, relapse prevention, employment, education, or legal issues.

**Referring Agency:** _____

**Worker's name:** _____ **Email address:** _____

**Contact Number:** _____ **Does the client consent to this referral?** *Yes* ☐ *No* ☐

**I wish to participate in FYRST. I give consent to the information on this referral form and extra information relating to this referral to be given to FYRST staff.**

_____ _____
**Client's signature** **Date**