Youthlink
fyrst
AOD Support Program

FYRST Eligibility Criteria

The client is aged between 12 and 25 years and:

- has a current or previous history of substance use
- lives within Sydney's Southwest LGAs or if outside the LGA is able to commute to the Southwest LGAs
- does not need immediate care for an acute psychiatric or physical illness
- consents to see FYRST staff, and be voluntarily involved with the FYRST program
- willing to enter case management and/or counselling to address drug & alcohol issues**,** or case management issues including assistance with housing options, relapse prevention, employment, education, or legal issues.

Does the client consent to this referral? Yes No

Client Details

Client name:

Is the above name listed on the client's birth certificate/other legal documents?
Yes No (If No, then please specify the name listed on legal documents)

DOB:

Gender identity: **Preferred pronouns:**

Gender listed on birth certificate/other legal documents (if different to the above):

Male Female

Street address:

Suburb: **Postcode:**

Contact number: **email:**

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Indigenous identity:

Country of birth: Australia Other (please specify)

Ethnicity: **Need for an interpreter:** Yes No

If yes, please specify the language above

Emergency contact details

Name:

Relation to the client:

Contact number:

Case management needs/assistance that may be required for the client:

(Please mark & provide further details in the box below)

AOD intervention	Education/training/
Psychological Intervention	Employment Legal support
Housing/accommodation	Other

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Briefly describe the client's AOD use (current and historical)

Does the client have any mental health concerns? Yes No
(If yes, please provide details):

Does the client have any disabilities? Yes No
(If yes, please provide details):

Please specify and provide details if the client presents with any of the following risks/safety concerns:

Suicidality Aggression

Self-harm Other

Homelessness

(Please provide details if any of the boxes have been ticked):

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Is the client receiving support from any other service/s, including services for mental health, AOD treatment/support, case management, legal or other needs?

Yes No

(If yes, please provide details

Referrer details

Date of referral:

Referrer name: **Service/organisation:**

Contact number: **Email:**