In-Home Withdrawal Service
Referral Form

The In-Home Withdrawal Service is for clients wishing to undergo withdrawal (detox) from low to moderate levels of substance dependence in the comfort of their own home. Clients will be supported by a team that includes a GP, Nurse, Senior Practitioners, Clinical Workers, Peer Workers, as well as support from a Significant Other.

All details below must be completed in full with all sections completed or the referral will be returned. Client (and/or Referrer) will be contacted upon referral received to inform of eligibility.

*Referrer is to send completed form by **Fax to Sonder (08) 8252 9433 or hand it in to a Sonder Office**. Any enquiries can be made by phone to (08) 8209 0700.*

Referral Source:	Self ☐ Community organisation ☐
Date of Referral:	

Client Details:

Name:			
DOB:		Gender:	
Address:			
Home No.:		Mobile No.:	
Does the client identify as an Aboriginal and/or Torres Strait Islander or of a Culturally and Linguistically Diverse background?	☐ Yes ☐ No If Yes, is an Interpreter required? ☐ Yes ☐ No If Yes, what is client's preferred language? _____		

Community Referrer Details (if applicable):

Name:		Role:	
Organisation:			
Phone:		Fax:	
Address:			

Referral Details:

What is the substance the client is most concerned about?	
Method of Use:	

Brief summary of client's pattern of use for their Principal Drug of Concern currently:

Does the client use any other substances regularly?	☐ Yes ☐ No If yes, what other substance(s) is the client using? 1. _____ 2. _____ 3. _____ If yes, the below ICD-10 criteria will need to be asked for each substance to determine if they are dependent on more than one substance.
Does the client also want to address the other substance(s) through this program?	☐ Yes ☐ No
Primary Reason for assistance?	Abstinence of AOD ☐ Yes ☐ No Controlled use of AOD ☐ Yes ☐ No Reduction of AOD use ☐ Yes ☐ No

Brief summary of client's pattern of use for their other substance(s) used currently:

Dependence Criteria:

ICD-11 criteria for a diagnosis of dependence requires the presence of three or more of the following at some time during the previous year.

Have any of the following been present in the previous 12 months for your Principal Drug of Concern?	**Yes = 1**	**No = O**
1. A strong desire or sense of compulsion to take the substance (craving).		
2. Difficulties in controlling substance-taking behaviour (for example levels of use, starting or stopping).		
3. A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.		
4. Evidence of tolerance, such that increased doses of the psychoactive substance are needed in order to achieve the same effects as originally produced by lower doses.		
5. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.		
6. Persisting with substance use despite clear evidence of overtly harmful consequences.		
Total Score:		

Notes (Include other scores if more than one substance is being used):

Inclusion Criteria:

Please complete to the best of your knowledge (Questions 2, 4, 5, and 9 can have possible response of 'Not Applicable').

Does the client have:	**Yes**	**No**	**Not Applicable**
Are you dependent to only one substance (excluding tobacco)?	☐	☐	
Have you ever experienced complicated withdrawal symptoms in the past (e.g. hallucinations, seizures, confusion, hospital admissions related to withdrawal)?	☐	☐	☐
A safe and stable home environment?	☐	☐	
Do you currently have any medical conditions? If yes, is that currently being managed (e.g. medications)? Please provide details in the space below.	☐	☐	☐
Do you currently have any mental health concerns? If yes, is that currently being managed (e.g. medications, psychologist, psychiatrist, counselling). Please provide details in the space below.	☐	☐	☐
Have you had any hospital admissions in relation to your mental health?	☐	☐	☐
An absence of aggressive behaviours (current or previously)?	☐	☐	
Do you currently have any thoughts of suicide or self-harm?	☐	☐	
Did you have any thoughts of suicide or self-harm in the past?	☐	☐	
Are you able to maintain and mange daily tasks effectively?	☐	☐	
Are you pregnant or thinking of conceiving in the next 12 months?	☐	☐	☐

Notes/Other Information:

Please provide details on any of the above as relevant (e.g. Medical conditions, psychiatric conditions, current treatment plans, or other psychosocial factors that will need to be considered?)

GP Details:

Does the client have an existing GP?		☐ Yes ☐ No *If yes, please provide details below.*	
Can we contact them?		☐ Yes ☐ No	
GP's Name:			
GP Practice:			
GP Address:			
Phone:		Fax:	

Support Person Details:

Does the client have a family member or friend who is over 18 and will be able to support the client through the withdrawal process?	☐ Yes ☐ No *If yes, please provide details below.*
Is the support person available to be at home with the client 24 hours a day during the withdrawal phase?	☐ Yes ☐ No
Will the support person be available for a phone assessment to deem their suitability?	☐ Yes ☐ No
Is the support person, able to attend a Precare appointment at our office?	☐ Yes ☐ No
Can we contact them?	☐ Yes ☐ No
Support Person's Name:	
Relationship to client:	
Phone:	

Consent for Self-Referral:

Client signature: _____ *Date:* _____

Consent for Community Referral:

I, _____ (client), agree to be referred to the Sonder In-Home Withdrawal Service and give my permission for_____ *(Referrer's full name)* to provide/receive written and verbal information to/from Sonder for the purpose of facilitating this referral.

Client signature: _____ *Date:* _____

Verbal Consent to release information (Phone Self-Referrals)

Do you give consent for the following services to be contacted? ☐ Yes ☐ No

Organisations	Information to be shared

How did you hear about us?	

Completed By

Sonder Worker: _____ Signature: _____

Role: _____ Date: _____/_____/_____

Please fax completed referral form to Sonder on (08) 8252 9433 or
Hand it into a Sonder Office:
2 Peachey Rd, Edinburgh North | 2/78-80 Dale Street, Port Adelaide