

Self-Referral Form

Alcohol & Other Drug Intervention
& Management (AIM)



Enquiry details	

Client Details

Name:		Date of birth:	
Residential address:			
Postal address:			
Is it safe to send mail to this address?	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Preferred contact method:	
Mobile number:		Is it safe to leave voicemail/SMS on this phone?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Email address:			

Emergency contact name:		Phone number:	
Relationship to client:			

Aboriginal/Torres Strait Islander status:	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander		
	<input type="checkbox"/> Both Aboriginal and Torres Strait Islander	<input type="checkbox"/> Neither		
Living with:	<input type="checkbox"/> Family	<input type="checkbox"/> Friends	<input type="checkbox"/> Alone	<input type="checkbox"/> Care home
	<input type="checkbox"/> Other _____			

GP Details

GP Name:	
GP Surgery:	

Completed by (name): _____ Date: _____

Signature: _____ Ph: _____

