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/Email to Sonder (08) 8252 9433 or ihws@sonder.net.au or hand it in to a Sonder Office. Any enquiries can be made by phone to (08) 8209 0700.***

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| --- | --- | --- | --- | --- | --- | --- |
| **Referral Source:** | **Self**  **Organisation**   **GP** | | **Date:** | |  | |
| **Client Details:** | | | | | | |
| **Name:** |  | | **Gender:** |  | | |
| **DOB:** |  | **Contact Number:** |  | | | |
| **Address:** |  | | | | | |
| **Email:** |  | | | | | |
| **Do you identify as:** | **Aboriginal**  **Torres Strait Islander**  **Aboriginal & Torres Strait** **Islander**  **Culturally & Linguistically Diverse**  **Will an interpreter be required?**  **Yes**  **No** | | | | | |
| **LGBTQI+ Status:** |  | | | | | |
| **Country of birth and preferred language** |  | | | | | |
| **GP Details:** | | | | | |
| **Name:** |  | **Phone:** |  | | |  | |
| **GP Practice:** |  | | | | |  | |

**Referrer Details (if applicable):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  | **Role:** |  |  |
| **Organisation:** |  | | |  |
| **Phone:** |  | **Email:** |  |  |

**Referral Details:**

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| |  |  | | --- | --- | | Substance of concern: |  | | Primary Reason for assistance: | Abstinence of AOD Yes No  Controlled use of AOD Yes No  Reduction of AOD use Yes No |   **Current substance use:**   |  |  |  |  | | --- | --- | --- | --- | | **Drug** | **Method** | **Amount/Frequency** | **Last used** | | ***Example: Cannabis*** | ***Smoke*** | ***2g per day*** | ***Today*** | | **Alcohol** |  |  |  | | **Cannabis** |  |  |  | | **Meth/Amphetamine** |  |  |  | | **Opiates** |  |  |  | | **GHB** |  |  |  | | **Benzodiazepine** |  |  |  | | **Cocaine** |  |  |  | | **Other** |  |  |  |   **Inclusion Criteria:**  Please complete to the best of your knowledge (Questions 1, 3, 4, 5 and 10 can have possible response of ‘Not Applicable’).   |  |  |  |  | | --- | --- | --- | --- | | **Does the client have:** | **Yes** | **No** | **Not Applicable** | | 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? |  |  |  | | History of aggression? |  |  |  | | 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 manage 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?) |

**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 |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |  |
| --- | --- |
| How did you hear about us? |  |

**Completed By**

Sonder Worker:

Role:

Date:

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