**INITIAL CONTACT FORM**

In order for us to assess if you are suitable for the Detour House program, we will require your information to be entered into a database and de-identified information provided to AIHW. Do you consent for us to provide this information? (Please Circle)

Yes No

|  |
| --- |
| Case Worker: Date:  |
| Client name:  |
| DOB/Age  |
| Phone numbers:  |
| Gender Identity/Preferred pronoun: Female/she |
| Are you homeless:  |
| If Yes to above, for how long:  |
| Address prior to most recent episode of homelessness |
| Current address:  |
| Are you living at this address now?  |
| Current source of income:  |
| ADF/NDIS membership?  |
| Occupation:  |
| Student Status: no |
| Country of birth:  |
| ATSI or CALD: no |
| Referred by: self. Was with Stepping Out but no more |
| **Rehab History (previous rehab of minimum 4 weeks essential)****Doesn’t have rehab experience**

|  |  |  |  |
| --- | --- | --- | --- |
| **When** | **Where** | **How long?** | **Other** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Email:  |
| Partner: |
| Children:  |
| Current children’s carer:  |
| FACS involvement in family: |
| Legal History;Pending court dates and details:  |
| Current AVOs Y/N:  |

**AOD History:**

In this section please describe the history of AOD usage. Include type of drug/alcohol, frequency, length of use and any other relevant information.

Have you used today?

[ ]  Yes

[ ]  No

# Current substance use

Are you abstinent: Yes/No\_\_\_\_\_\_days

Detox\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug/Substance   |  |  |  |  |
| Duration   |  |  |  |  |
| Last used   |  |  |  |  |

Support Networks Friends Family NA/AA Counsellor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a mental health diagnosis?

[ ]  Yes Are you taking your prescribed medication? **Y/N**

[ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis** | **Doctor** | **Medication & Dosage** | **How long?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you been in hospital, prison or a psychiatric ward in the last 12 months?

[ ]  Yes

[ ]  No

If yes, details:

Do you have a history of self-harm?

[ ]  Yes

[ ]  No

**Medical History:**

Have you had any major or chronic illnesses, accidents in the past or current physical medical conditions?

[ ]  Yes

[ ]  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnosis** | **Doctor** | **Medication** | **Dose** | **How Long** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Have you ever been diagnosed with an eating disorder?

[ ]  Yes

[ ]  No

Details:

Are you pregnant?

[ ]  Yes

[ ]  No

If yes, due date:

**Family and Domestic Violence**

Within the last year have you been hit, slapped or hurt in anyway by your partner or ex-partner?

[ ]  Yes

[ ]  No

Are you frightened of your partner or ex-partner?

[ ]  Yes

[ ]  No

If you are accepted into the program are you safe to go home afterwards?

[ ]  Yes

[ ]  No

Would you like some assistance with this?

[ ]  Yes

[ ]  No

Do you have a history of violent or aggressive behaviour?

[ ]  Yes

[ ]  No

**Assessment Summary and Outcome**:

Suitable for Detour House?

[ ]  Yes

[ ]  No (please complete Referral to other service and discuss with General Manager)

Discharge Summary provided? Y/N

Place on Waiting List?

[ ]  Yes, pending receipt of discharge summary

[ ]  No (please complete Referral to other service)

Further pre-admission information required?

[ ]  Yes

[ ]  No

Details:

Referral to other service:

Additional comments: