**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: