CatholicCare Social Services Hunter - Manning
DIOCESE OF MAITLAND-NEWCASTLE

32-34 Pulteney Street, PO Box 4, Taree NSW 2430
P 02 6539 5900 F 02 6539 5979
E AODTCC@catholiccare.org.au
www.catholiccare.org.au

AOD Transitional Care Referral Form
Private and Confidential

Client Consent and Privacy

All services and supports provided by CatholicCare are voluntary. Please confirm that you have client consent for this referral by placing a tick in the relevant box. All information is handled in accordance with our privacy policy.

☐ Written Consent ☐ Verbal Consent ☐ N/A – Self Referral

Client Personal Details

Name _____ Date of Birth _____

Address _____

Gender: ☐ Male ☐ Female ☐ Other (please specify) _____

Does the person identify as indigenous? ☐ Yes ☐ No

If Yes, ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Indigenous Country/Nation _____ Indigenous Language _____

Translator required ☐ Yes ☐ No

Please provide details of how the client wishes to be contacted by CatholicCare to arrange an appointment - you may place a cross in multiple boxes

☐ Phone # _____ Can we leave a message on this phone? ☐ Yes ☐ No

Most convenient time to call _____ If mobile, can we send an SMS? ☐ Yes ☐ No

☐ Email _____ ☐ Letter to home address

☐ Letter to alternate address (provide details) _____

Services Required – you may place a cross in multiple boxes

AOD Transitional Care ☐ Taree ☐ Forster ☐ Other

Eligibility Criteria for AOD Transitions Program.
Note: A referred client does not need to meet ALL the criteria to be eligible for the program. Each client referral will be assessed on a case-by-case basis taking into consideration all their circumstances before a decision is made

	Criteria	Meets Criteria? *(Please tick)*	
		Yes	No
1	Aboriginal and Torres Strait Islander person - 18 to 65 years of age	☐	☐
2	Pregnant woman and/or those with young children	☐	☐
3	Person with co-occurring substance misuse and mental illness (dual diagnosis)	☐	☐
4	Person living in a rural or remote area	☐	☐
5	Person with low income or on unemployment benefits	☐	☐
6	Person with recent suicide attempt or suicidal behaviour or ideation	☐	☐
7	Person with alcohol or substance use dependency	☐	☐
8	Person with a chronic disease	☐	☐
9	Person with family relationship instability	☐	☐
10	Person classed as being in poverty (income less than AUD $426.30 per week).	☐	☐
11	Person with forensic psychosocial or psychiatric related issues	☐	☐
12	Person with chronic pain	☐	☐
13	Person exiting a custodial facility	☐	☐
14	Person exiting a residential treatment facility	☐	☐
15	Person with limited employment/education opportunities and social exclusion	☐	☐
16	Person with complex trauma which affects functioning	☐	☐
17	Person with housing instability	☐	☐

	Exclusions	Meets Criteria? *(Please tick)*	
		Yes	No
1	Person is facing sentencing thought the judicial system from an existing case	☐	☐
2	Person has a diagnosis of an eating disorder	☐	☐
3	A primary diagnosis of cancer	☐	☐
4	Enrolment in the National Disability Insurance Scheme (NDIS) or Continuity of Support (CoS) program	☐	☐
5	Person is seen as a risk to the safety of the Transitional Coordinator	☐	☐

Reason for Referral

Presenting Mental Health Issue e.g. Diagnosis, issue - anxiety, depression, etc.

Drug and/or Alcohol Issue e.g. alcohol, cannabis

Other Health Issues or Psychosocial Factors E.g. medical factors, other diagnosis, homelessness, stress, social situation

Risk Factors e.g. Harm to self or others, suicide risk, vulnerability

Other relevant information

Person Making Referral

Name _____ Date of Referral _____

Organisation _____

Phone _____ Fax _____ Email _____

Please email referral to:

AODTCC@catholiccare.org.au