



NeRASP (North East Recovery and Support Program) Referral Form

To be completed by referring staff member with the client or by the individual who is making a self-referral.

Clients Details

Name:

Date of Birth:

Phone Number:

Address:

Referrers Details

Name:

Phone Number:

Organisation:

Provide a brief history of current substance use.

Provide a brief history of current mental health issue, indicate if diagnosed by professional or other.

Does the client identify as being impacted by any trauma (physical, sexual, emotional abuse, or a single incident)?

Is the client currently linked in with any other services?

Main motivation and goals for attending program.

How **IMPORTANT** is it to you to make this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely

How **CONFIDENT** do you feel in making this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely

How **READY** are you to make this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely

I consent to this information being exchanged with Banyule Community Health. I understand that completing this form does not guarantee a place in the NeRASP program.

Client Signed: _____