Intake Form

Eastern Dual Diagnosis /FAN

Referrer Information

Date of referral .....

Worker .....

Position .....

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Reason for Referral

☐ Help with assessment ☐ Secondary consultation ☐ Treatment recommendations

☐ Short term intervention ☐ Referral options ☐ Crisis Response

☐ Relapse/Recovery Issues ☐ Other

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Young Person Information

Name ..... Young person aware of referral? ☐ Yes ☐ No

DOB .....

Contact details .....

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MH history .....

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AOD history .....

(incl. stage of change) .....

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Risk Issues .....

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Management Plan .....

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Services Involved .....

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Revised 1/09

TO BE COMPLETED BY HYDDI WORKER

Other information (attach if available/applicable)

E.g. Risk, MSE, Forensic, Developmental, Psychosocial, Physical wellbeing, Consumer attitude to referral, Therapeutic alliance, other agencies involved

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Summary / Formulation

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Immediate response by Dual Diagnosis Clinician

☐ Assessment booked ☐ 2° consultation provided ☐ Advice re: management of risk

☐ Referral to other service facilitated

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Recommendations / Outcome

☐ Primary consultation ☐ Secondary consultation ☐ Tertiary consultation

☐ Case Conference Input ☐ Discussed during individual clinical supervision; specify date: ……

☐ Change in Agency policy/protocol ☐ Discussed at EDDS Clinical review meeting; specify date: ……

☐ Feedback to be given to consumer and carers (specify below)

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Follow- up required? ☐ Yes ☐ No (If yes, please specify: reasons for follow-up, type of follow-up, timeframe, etc.)

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Documentation

☐ CRAM form completed ☐ Contact(s) recorded on Contact Sheet ☐ Progress notes in EH file

☐ Letter / report sent to referrer ☐ Copy of letter / report in DualDiag folder

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Dual Diagnosis Clinician **Signature** **Date**