

# GOLD COAST DRUG COUNCIL INC

## Program Referral Form

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Date of referral...../...../.....      Is the client aware of this referral? Yes / No

Agency name.....Area office.....

Contact person.....

Phone.....Fax.....Email.....

**Person's Details:**

First Name.....Last Name.....

Date of Birth .....Gender Male/Female/Transgender

Phone.....Mobile.....Email.....

Address.....

**Significant other persons:**

First Name	Last Name	Relationship to client	D.O.B.	Gender

Reason for referral.....

.....

Other agencies involved.....

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.....

Their role?.....

.....

Identified needs.....  
.....  
.....  
.....

**Intervention Program ? (Please tick relevant boxes)**

- |                                  |                          |                       |                          |
|----------------------------------|--------------------------|-----------------------|--------------------------|
| Residential Rehabilitation       | <input type="checkbox"/> | Dual Diagnosis        | <input type="checkbox"/> |
| Youth Drug & Alcohol Counselling | <input type="checkbox"/> | Family Therapy        | <input type="checkbox"/> |
| Stop Pot Program                 | <input type="checkbox"/> | Group work/activities | <input type="checkbox"/> |
| DRASTIC Program                  | <input type="checkbox"/> | Young Family Support  | <input type="checkbox"/> |

Other .....  
.....  
.....  
.....

**Additional information**

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.....  
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**Please send completed referral form to:**

**Fax:** 55762512    **Email:** [admin@gcdrugcouncil.org.au](mailto:admin@gcdrugcouncil.org.au)

**Post:** Gold Coast Drug Council (referrals)  
PO Box 2655  
Burleigh BC 4220

**Phone:** (07) 55354302

N.B. An appointment must be negotiated with the GCDC for Assessment:

**OUTCOME**                      **Accepted**                      Yes      No  
**If NO referred to:** \_\_\_\_\_