REFERRAL FORM

Alcohol, Other Drugs or Gambling Counselling

Amity
Community Services Inc

Details of the person for whom the referral is being made

First name: 　　Family name:

Date of birth: 　　Male ☐ 　Female ☐ 　X ☐ (Indeterminate/Interex/Unspecified)

Address:

Preferred phone: 　　Alternative phone:

Referee's details

Name:

Agency/Practice name:

Contact *(please indicate preferred form)*:

Phone: 　　Fax:

Email: 　　Address:

Reason for referral

Release of information

I, 　　consent for information regarding my:

Referral only ☐ 　Referral and ongoing counselling ☐

to be exchanged between my 　　*(eg. GP, case worker)* and Amity Community Services.

I consent to Amity leaving a message on my contact numbers above if necessary 　YES ☐ 　NO ☐

Signature: 　　Date:

Witness name: 　　Witness signature: 　　Date:

Client to phone to book appointment on (08) 8944 6565

Email: habitwise@amity.org.au
Fax: (08) 8981 8456
Address: 155 Stuart Highway Parap NT 0820
Mail: GPO Box 3628 Darwin NT 0801