



7 Mile Rehabilitation Centre Referral

Ph: (08) 9161 1806 Fax: (08) 9161 1807
Email: intake@ngnowar.org.au

Ngnowar-Aerwah
Aboriginal Corporation
PO Box 250 Wyndham
WA 6740

Please make sure when filling out the referral form to answer all questions, otherwise the referral cannot be processed and will be returned for further information which may result in significant delays.

Date of Application:/...../.....

Applicant referred by: _____ Referral Agency _____

Email address* (for correspondence): _____ **REQUIRED**

Telephone Number _____ Fax Number _____

CLIENT DETAILS

Name: _____

Address: _____

Phone: _____

DOB: ____/____/____ Place of Birth: _____

Gender: Male ☐ Female: ☐

Indigenous Status: Aboriginal ☐ Non Aboriginal ☐

Marital Status: Single ☐ Married ☐ Separated ☐ Defacto ☐

Is your partner also applying?: _____

If yes, what is their name?: _____

Children's names and ages (**only complete if they are coming with you**): _____

Are the children in CPFS care? Yes ☐ No ☐

Identification: Birth certificate: ☐ Drivers license: ☐ Bank Account: ☐
Social security Card: ☐ Over 18 ID ☐

ID Details: _____

Healthcare card: _____ Medicare Number: _____



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Next of Kin: Name: _____ Relationship: _____

Emergency Contact: Name: _____

Relationship: _____ Tel: _____

Client's
own
words

Why does the client want to attend rehab?

* Mandatory question

*Please prompt the client to provide a sentence.

Main Drug of Concern: _____

Frequency of substance use: (eg. Daily, weekly, monthly, binge) _____

Other drug use: _____

Has the client been through a period of Detox recently? Yes: ☐

No: ☐

If yes please provide details,

Period of Detox _____ Start Date: _____ Completion Date _____

Drug Detoxing from _____

List any ongoing or follow up medications to manage withdrawal symptoms

Medical health condition(s) within the past 3yrs: _____

Mental health condition(s): _____

List any current prescribed medications _____

List any known allergies _____



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Risk of Self Harm/Suicide Assessment

Previous suicide attempt(s) within the last 3 years: NO ☐ YES ☐

Current suicidal ideation: NO ☐ YES ☐

Have you ever done anything, started to do anything, or prepared to do anything to end your life? NO ☐ YES ☐

If yes, how long ago:

Over a year ago?	Between three months and a year ago?	Within the last three months?
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Self Harm or Suicide					Harm to Others					Vulnerability-cannot look after self		
1	2	3	4	5	1	2	3	4	5	1	2	3
Follow up action plan/ notes:										1. Able to care for themselves, hygiene, feeding and mobility.		
										2. Some poor hygiene and self care but able to look after basic needs adequately.		
										3. Needs assistance to toilet, unable to comprehend simple instructions.		

A score of 5 is at the extreme risk of suicide or self harm, 4 at very high risk, 3 at high risk, 2 medium risk and 1 at low risk.



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Note: This form is not able to be processed until this section is completed:

Do you have any criminal convictions or pending charges?

NO ☐ YES ☐ - Complete the following

Do you have convictions or pending charges for:
(tick)

sexual assault? ☐ Murder? ☐ Assault? ☐ Other? ☐

If the client is in prison, please state the reason and release date:

Court orders from the last 3 yrs: _____

Any restraining Orders: Yes: ☐ No: ☐

Details of restraining orders if any including date and persons concerned: _____

Pending court appearances if any: _____

Report required: Y / N

If yes, please provide details: _____

list any agencies working with the client along with a contact person:

Agency	Contact



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I agree and give consent for the Ngnowar Aerwah Rehab Centre Intake Management Team to provide my identification details to the relevant agencies to carry out a risk assessment. I also understand that once this occurs Ngnowar Aerwah is no longer responsible for the risk assessment outcomes. I understand that if my risk assessment is rated high or extreme, I will not be accepted into the program and my application declined.

I also consent to the Ngnowar-Aerwah 7 Mile Rehab Centre staff to provide a report on my progress as required to the referring agency.

As the client signing this I agree that all the information provided is accurate. I understand if I give misleading information or leave out information about serious criminal history I can be discharged from the program.

Client Signature*: _____ Date: _____

*Client must sign referral for it to be processed.

Applicant referred for:

Tick all that apply

General Counselling
AOD Counselling
Rehab Program -15 Weeks

☐
☐
☐

Rehab admission / accommodation required

Single
Couple
Family

☐ (by yourself)
☐ (with partner)
☐ (with children)

Office Use Only

Nominated Ngnowar-Aerwah Counsellor: _____

Date: _____