

## Directions Post-Custodial Support



### REFERRAL FORM

#### REFERRER'S DETAILS

Referring organisation:		Date of Referral:
Referrers name:	Position/Role:	
Referrers contact no:	Referrers email:	
Is the referring agency / officer expecting to be informed of the outcomes of Directions' engagement? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please tick the office this referral will be for: Wagga Wagga <input type="checkbox"/> Griffith <input type="checkbox"/> Goulburn <input type="checkbox"/> Moruya <input type="checkbox"/> Bega <input type="checkbox"/> Cooma <input type="checkbox"/>		

#### CLIENT DETAILS

First Name:		Surname:
DOB:	MIN:	Country of Birth:
Aboriginal Status: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/>		
Does the client identify as Culturally or Linguistically Diverse (CALD)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Language spoken:		Will a translator be required? Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Trans man <input type="checkbox"/> Trans woman <input type="checkbox"/> Another term <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>		
Pronouns: he/him/his <input type="checkbox"/> she/her/hers <input type="checkbox"/> they/them/their <input type="checkbox"/>		
Address upon release:		
Contact person upon release (name):	Number:	Relationship:

#### INCARCERATION / RELEASE DETAILS

Correctional Centre:	Convicted: Yes <input type="checkbox"/> No <input type="checkbox"/>
Sentence:	Release Date:
<b>Parole Conditions</b> (are there any parole conditions that the person may need support with?) Type of order in place: ..... Length of order/End date: ..... Requirements: ..... Child or Family Protection Order: ..... Other notes: .....	

#### RISK SUPPORT

Please include any known risks of harm to self (suicidality), risk of harm to others (aggressive behaviours) and/or risk of harm from others (e.g. domestic violence risks upon release) ..... ..... .....
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REFERRAL DETAILS

Reason for referral (please include any substance use issues that may arise on release)

Mental Health (please provide a brief description of the person's mental health needs and any relevant history and support needs)

Physical health (please provide a brief description of the person's physical health needs and any relevant history and support needs)

Is the client on treatment for opioid use disorder? Yes No

Accommodation

Will they have accommodation upon release? Yes No Unsure

Will they need support finding new accommodation? Yes No Unsure

Supports (does the person have any natural or service supports upon release?) Please provide names and numbers of key contacts.

Other needs/comments

CLIENT CONSENT

Please confirm that the client has consented to the referral as Post-Custodial Support is a voluntary program:

Yes

- Please email this completed form to: **postcustodial@directionshealth.com**
- Directions ensures that personal information is confidential and treated respectfully
- Clients will be contacted by a team member generally within 7 days

## Directions Post-Custodial Support

- For further information or enquires please phone 02 6132 4800 and ask to speak to the Post-Custodial Lead or email [postcustodial@directionshealth.com](mailto:postcustodial@directionshealth.com)

