SMART Recovery Client Referral Form

Referral date (dd/mm/yyyy)	
Contact Method	☐ Telephone ☐ In Person ☐ Email ☐ Letter ☐ Other

Referral Source Details	
Name	
Service/Program	
Phone/Mobile number	
Email	

Client Details			
Surname			
Given name(s)			
Preferred name			
Date of birth (dd/mm/yyyy)		Or Age	
Gender	☐ Male ☐ Female ☐ Non-binary ☐ Other:		
Preferred pronouns	e.g.: They/Them/Theirs; She/Her/Hers; He/Him/His		
Phone/Mobile number			
Primary substance of concern			
How did the client hear about this program?	☐ Word of Mouth ☐ Clinician ☐ SMART Website ☐ TF Website ☐ Other		

Has the client attended other groups before? (e.g.: AA groups, AOD counselling groups, rehabilitation groups, etc)

☐ Yes ☐ No

If yes, please specify which one(s):

Would the client be open to having a brief intake/assessment with the facilitator prior to joining the group to get a fuller picture of their circumstances and needs?

☐ Yes ☐ No

I _____ consent to the sharing of information between TaskForce clinical staff relevant to my treatment.

TASKFORCE COMMUNITY AGENCY

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