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			

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

TASKFORCE COMMUNITY AGENCY
421 South Road, Bentleigh VIC 3204 | taskforce.org.au
03 9532 0811 | enquiries@taskforce.org.au
ABN: 48 909 624 457