



## Alternative to Custody Referral Form

### REFERRING'S INFORMATION:

Referral Date: \_\_\_ / \_\_\_ / \_\_\_

Organisation: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

### APPLICANT'S INFORMATION:

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Also known as: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_

Aboriginal or  Torres Strait Islander

Community: \_\_\_\_\_

Language(s) spoken: \_\_\_\_\_

Interpreter requested  Yes /  No Language required: \_\_\_\_\_

Interpreter used  Yes /  No If No,

Why: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_

Postcode: \_\_\_\_\_

### CURRENT LEGAL SITUATION:

The applicant is currently:

- Incarcerated sentenced
- Incarcerated remand
- Released (no conditions)
- Supervised by Community Corrections
- Bail
- Other: \_\_\_\_\_

Charged with: \_\_\_\_\_

Sentenced for: \_\_\_\_\_

Supervision order: \_\_\_\_\_

Date of Incarceration:

\_\_\_ / \_\_\_ / \_\_\_

If on remand, next court:

\_\_\_ / \_\_\_ / \_\_\_

Date of eligibility for parole:

\_\_\_ / \_\_\_ / \_\_\_

Full term release date:

\_\_\_ / \_\_\_ / \_\_\_



**ORDERS PREVENTING CONTACT WITH OTHER PEOPLE:**

Are there any legal or current orders (e.g. Domestic Violence Orders) in place?

Yes  No

Against the referring applicant?  Yes  No      Against someone else?  Yes  No

If yes, please provide details: \_\_\_\_\_

**ESSENTIAL INFORMATION:**

Does the applicant have any:

Medical Issues  If yes, please provide relevant information

Mental Health  If yes, please provide relevant information

Alcohol and other drugs  If yes, please provide relevant information

**REASON FOR REFERRAL / ADDITIONAL INFORMATION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FURTHER DOCUMENTS ATTACHED (where applicable):**

- |   |  |
|---|--|
| <input type="checkbox"/> Criminal history                               | <input type="checkbox"/> Domestic Violence Order                   |
| <input type="checkbox"/> Mental Health Report(s)                        | <input type="checkbox"/> Cognitive assessment                      |
| <input type="checkbox"/> Medication Management Plan                     | <input type="checkbox"/> Mental Health Plan                        |
| <input type="checkbox"/> Letter to referral agency<br>sentence, parole) | <input type="checkbox"/> Any relevant orders (i.e, bail, suspended |
| <input type="checkbox"/> Other _____:                                   |  |



**APPLICANT CONSENT TO SHARING OF INFORMATION:**

The purpose of this form has been discussed with me and I give permission for the above information regarding myself to be exchanged and collected with the Drug & Alcohol Services Australia (DASA), Central Australian Aboriginal Congress and the referring agency for the purpose of the Alternative to Custody program.

Signature of applicant: \_\_\_\_\_ Verbal consent:  Yes  No

Date: \_\_\_/\_\_\_/\_\_\_

Signature of referring person: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

I also give consent for Central Australian Aboriginal Congress social worker to access relevant information from Central Australian Aboriginal Congress medical records as part of the intake process

Signature of applicant: \_\_\_\_\_ Verbal consent:  Yes  No

Date: \_\_\_/\_\_\_/\_\_\_

Signature of referring person: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**APPLICANT CONSENT PARTICIPATION IN PROGRAM:**

I understand and consent to engaged and participate with DASA Alternatives to Custody program.

Signature of applicant: \_\_\_\_\_ Verbal consent:  Yes  No

Date: \_\_\_/\_\_\_/\_\_\_

Signature of referring person: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**Email Referral to: [atcintake@dasa.org.au](mailto:atcintake@dasa.org.au)**

(Subject to legal issues and at the discretion of the Alternative to Custody Working Group)