



**Queensland
Government**
Queensland Health

Alcohol, Tobacco and Other Drug Services *Referral Form*

242 Walker Street, Townsville QLD 4810
Phone: (07) 4778 9677
Fax: (07) 4778 9666

Referral Date: _____

Referral From (eg GP, hospital ward):

Agency	
Contact Name	
Phone No.	
Fax No.	
Address	

Client's Details (Hospital Label):

Surname	
Given Name(s)	
Address	
Phone	
D.O.B.	

Reason for Referral

Alcohol and Drug History

Other Relevant History

This referral is made in consultation with the client. The client agrees to accept both the referral and feedback between services / agencies.

Worker's Signature _____

Name *(Please Print)* _____

Designation _____

Date/...../.....

Client's Signature _____

Name *(Please Print)* _____

Date/...../.....