Queensland Government

Gold Coast Health

ADAPT REFERRAL FORM

Facility:……..

(Affix identification label here)

URN:

Family name:

Given name (s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date: __/__/___ Referrer Name: _____ Designation: _____ Signature: _____

Organisation: _____ Phone: _____ Fax: _____

Client Name: _____ **DOB:** _____ **Contact Number: (m)** _____ **(H)** _____

Primary Drug(s) of Choice: _____ **Treating Doctor:**_____ **Phone:** _____

Client Address:_____ **p/c:** _____

Employment status/Occupation: _____ **Hours p/w: -**_____

Will the client be able to attended every session (8 x weeks and 3 x follow up sessions): Yes ☐ **No** ☐ **Unknown** ☐

Current Medications: _____

Past Assessments/treatments/groups: _____

Mental Health & Drug Screen:

	Mental Health			**Drug Description & Specifications**	**Drug & Alcohol**			
	Diagnosis	Past	Current	Alcohol: _____	Frequency	Quantity	Past	Current
Anxiety (*OCD, Social Anxiety, Panic, PTSD…)*				Nicotine: _____				
Mood (*Major Depression, Bi-Polar, Dysthymia…)*				Cannabis: _____				
Psychosis (*Schizophrenia, drug induced psychosis…)*				Amphetamine: _____				
Eating Disorder (*Anorexia Nervosa, Bulimia Nervosa…)*				Heroin: _____				
Grief/Bereavement				MDMA: _____				
ADHD				Benzodiazepine: _____				
Learning Disorder				Cocaine: _____				
Personality Disorder/Traits (*Dependent, Avoidant, Antisocial, Borderline*				Inhalants: _____				
Other				Hallucinogens: _____				
				Opioids (other): _____				
				Prescriptions: _____				
				Other:				

Possible Exclusion criteria:

☐ Acute psychotic symptoms ☐ Current Suicidality ☐ Recent Aggressive behaviour
☐ Cultural/Language factors ☐ Cognitive Impairment ☐ Homelessness

Thank You

Office Use Only: Date referral received: ___/___/_____ **Outcome**: ☐ Not accepted ☐ Further info needed ☐ Accepted

Date of initial assessment: __/__/____ Clinician Appointed: _____ Clinician Signature: _____

Case Review Date: __/__/____ Further Info/comments: _____

ADAPT

ALCOHOL DRUG ACCEPTANCE PREVENTION THERAPY

Aim

- Include Dual Diagnosis therapy program in service provision
- Build on participants existing skills using Acceptance & Commitment Therapy (ACT) model
- Formalise AODS & MHS Partnership
- Enable participants to better manage thoughts and feelings

Rationale

- Treatment of Dual Diagnosis is a Qld Health requirement
- BIC participant evaluation has identified the need for a more comprehensive therapy program
- Research supports the use of ACT interventions in substance abuse treatment
- ACT is compatible with:
    - CBT
    - AA and NA
    - Medication
    - Biopsychosocial approach
    - Holistic perspective
    - A Wide range of therapies and services

Referral Pathway

- Participant or referrer must contact AODS directly:
    - David Pinchin ph 5525 5701/ david.pinchin@health.qld.gov.au / fax: 55255701
- Complete ADAPT referral form and return via fax/email to AODS
- Participants will be Case Managed by AODS upon acceptance, if not already Case Managed by MH
- Referrers and potential participants will be notified of receipt of referral and the assessment outcome

Criteria

- Participant has a current/past mental health diagnosis
- Participant has a current or past history of substance abuse
- Participant has no acute mental health symptoms
- Participant recognises the need for change
- Participant has completed a recognised Relapse Prevention program in the last 12 months
- Participant has signed an ADAPT Treatment Contract

Please feel free to contact David 5525 5701 (Palm Beach) at AODS, if you require further information regarding ADAPT.

NOTE: RERRERAL FORM AVAILABLE OVER PAGE

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DO NOT WRITE IN THIS BINDING MARGIN