Youthlink

fyrst

AOD Support Program

FYRST Eligibility Criteria

The client is aged between 12 and 25 years and:

- has a current or previous history of substance use
- lives within Sydney's Southwest LGAs or if outside the LGA is able to commute to the Southwest LGAs
- does not need immediate care for an acute psychiatric or physical illness
- consents to see FYRST staff, and be voluntarily involved with the FYRST program
- willing to enter case management and/or counselling to address drug & alcohol issues, or case management issues including assistance with housing options, relapse prevention, employment, education, or legal issues.

Does the client consent to this referral? Yes No

Client Details

Client name:

Is the above name listed on the client's birth certificate/other legal documents?
Yes No (If No, then please specify the name listed on legal documents)

DOB:

Gender identity: **Preferred pronouns:**

Gender listed on birth certificate/other legal documents (if different to the above):

Male Female

Street address:

Suburb: **Postcode:**

Contact number: **email:**

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Indigenous identity:

Country of birth: Australia Other (please specify)

Ethnicity: **Need for an interpreter:** Yes No

If yes, please specify the language above

<u>Emergency contact details</u>

Name:

Relation to the client:

Contact number:

Case management needs/assistance that may be required for the client:

(Please mark & provide further details in the box below)

AOD intervention	Education/training/employment
Counselling	Legal support
Housing/accommodation	Other

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Briefly describe the client's AOD use (current and historical)

Does the client have any mental health concerns? Yes No
(If yes, please provide details):

Does the client have any disabilities? Yes No
(If yes, please provide details):

Please specify and provide details if the client presents with any of the following risks/safety concerns:

Suicidality
Aggression
Self-harm
Other
Homelessness

(Please provide details if any of the boxes have been ticked):

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Is the client receiving support from any other service/s, including services for mental health, AOD treatment/support, case management, legal or other needs?

Yes No

(If yes, please provide details

Referrer details

Date of referral:

Referrer name: **Service/organisation:**

Contact number: **Email:**