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**Residential Recovery Centre**

***Client Referral & Assessment Application Kit***

***Phone: (07) 4056 9000***

***Email:*** ***referrals@gindaja.org***

***Web:*** [***www.gindaja.org.au***](http://www.gindaja.org.au)

***@GindajaHealing***

**About Gindaja**

Gindaja is an Indigenous community-controlled organisation dedicated to improving the wellbeing of Aboriginal and Torres Strait Islander people who experience problematic alcohol and/or substance dependency.

Gindaja operates a 17 bed Residential Recovery Centre located in Back Beach Road, Yarrabah as well as a day-based Learning and Wellbeing Centre in the central Yarrabah Township.

Gindaja’s Residential Recovery Centre provides 24/7 care and support for people to recover and heal from alcohol and other drug dependency. The Centre has a capacity for up to 17 residents, each undertaking a 12 week (3 month) residential recovery program.

The Centre is staffed by Indigenous workers, most of who come from the local Yarrabah community and includes 2 Aboriginal Health Workers to attend to resident’s physical health needs. All workers are trained in case management and program facilitation and have a wide range of personal life experience and learnings.

Gindaja’s Residential Program is grounded in an Indigenous model of holistic health and takes a strengths-based, social and emotional wellbeing (SEWB) approach to recovery and healing. Group day programs are facilitated in the morning and afternoon and include: AOD Education (Connecting the Dots…); Anger Management (Don’t Get Me Wild…); Family Wellbeing Empowerment Program; Relapse Prevention; and Gindaja’s Heart to Art Bama class among others. The Program also includes a range of cultural and recreational activities for residents such as: visiting important traditional locations; fishing; town trips; going out to country; attending local events; attending AA/NA meetings; and day trips to Yarrabah/Cairns swimming holes (especially during the summer!)

**Please Note: This application form is a fillable form and designed to be completed on your computer – it is our preference that this form is typed. It is also printer friendly if you need to complete it by hand, but we ask you to write clearly and legibly.**

**Eligibility**

People wishing to participate in Gindaja’s Residential Recovery Program must:

[ ]  Be 18 years of age or over

[ ]  Identify AOD dependence as the main issue of concern

[ ]  Have written medical confirmation that detoxification has been completed or is not required

[ ]  Be clean and sober upon admission

[ ]  Be willing and able to participate in all treatment activities and abide by Gindaja’s rules and policies

[ ]  Be fully vaccinated for COVID 19 and provide an Australian approved vaccination certificate

**NOTE: If you have ticked all the boxes above, please continue with your application**

Gindaja **does not** have the capacity to accept the following:

* People with a severe mental health condition/illness.
* Those who are taking S8 medications.
* People who are physically or mentally unable to participate in the program.
* People who have been convicted of a sexual offence in the last 5 years.

**NOTE: If any of the above applies to you, please do not continue as we will be unable to accept your application.**

**1 Client Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Date of Birth:** | Click to enter a date. |
| **Middle Name:** |  | **Age:** |  |
| **Last Name:** |  | **Gender:** |  |
| **Address:** |  |
| **State:** | Please select a state | **Post Code:** |  |
| **Email:** |  | **Phone:** |  |
| **Indigenous Status** | [ ]  Aboriginal | [ ]  Torres Strait Islander |
| [ ]  Both Aboriginal & Torres Strait Islander | [ ]  South Sea Islander |
| [ ]  Non-Indigenous | [ ]  Other: SSI & Iris |
| **Who is your Mob?** |  |
| **Medicare Card:** | *Number:* | **Expiry Date:** | Click to enter a date. |
| **CRN/Health Care Card:** | *Number:* | **Expiry Date:** | Click to enter a date. |

**2 Referring Worker Details**

**Note:** If ‘Self’ referred, go to next section. If referred by a friend/family member complete the section below with name, address and contact details.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referral Type:** | [ ]  Self/Family:*Please specify:*Click to enter text. | [ ]  Court/Corrections:*Please specify:*Click to enter text. | [ ]  Health/Medical:*Please specify:*Click to enter text. | [ ]  Other:*Please specify:*Click to enter text. |
| **Organisation Name:** |  |
| **Address:** |  |
| **State:** | Please select a state | **Post Code:** |  |
| **Workers Name:** |  | **Phone:** |  |
| **Email:** |  |
| **Position Title:** |  |

**3 Current Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Housing:** | [ ]  Social Housing | [ ]  Public Housing | [ ]  Private Rental |
| [ ]  Council Rental | [ ]  With Friends/Family | [ ]  Women’s Refuge |
| [ ]  Supported Housing | [ ]  Crisis/Emergency Accom. | [ ]  Incarcerated |
| [ ]  Other (Please specify) | Click to enter text. |
| **Income** | [ ]  JobSeeker/Newstart | [ ]  Parenting Payment | [ ]  Youth Allowance |
| [ ]  Age Pension | [ ]  Disability Support Pension | [ ]  Carer Payment |
| [ ]  Employment | [ ]  Other (Please specify) Click to enter text. |
| **Marital Status:** | [ ]  Single | [ ]  Married | [ ]  Defacto |
| [ ]  Divorced | [ ]  Separated | [ ]  Widowed |
| [ ]  Other (Please describe): Click to enter text. |
| Partners Name: |
| **Children:** | Do you have children? [ ]  Yes [ ]  No |
| If ‘Yes’, how many children? |
| What are their ages? |
| Is child safety involved? [ ]  Yes [ ]  No |
| If ‘Yes’, please briefly describe your situation: |
| **Legal:** | Do you have a criminal history? [ ]  Yes [ ]  No |
| If ‘Yes’, please provide brief details *(e.g., offense, year, sentence)*: |
| Do you have a current DVO or AVO? [ ]  Yes [ ]  No |
| If ‘Yes’, is the DVO/AVO against: [ ]  You? [ ]  Someone Else? |
| Do you have any pending court cases? [ ]  Yes [ ]  No |
| If ‘Yes’, please provide brief details *(e.g., when, where?)*: |

**4 Emergency Contacts** (Who can we contact in case of emergency?)

**Preferred Contact:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Address:** |  |
| **State:** | Choose an item. | **Post Code:** |  |
| **Email:** |  | **Phone:** |  |

**Secondary Contact:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Address:** |  |
| **State:** | Choose an item. | **Post Code:** |  |
| **Email:** |  | **Phone:** |  |
| Is there any person who you **do not** want to be in contact with while you are at Gindaja? |
| **Name:** |  | **Relationship** |  |
| **Name:** |  | **Relationship** |  |

**5 Alcohol/Drug Dependence**

The following questions ask about what drug (including alcohol) you were most concerned about in the last 6 months and how you feel about your using/drinking. Please answer as honestly as possible by ticking the answer that is right for you.

**5.1 Over the last 6 months, what drug/s has caused you the most concern?**

|  |  |  |
| --- | --- | --- |
| [ ]  Alcohol | [ ]  Cannabis | [ ]  Amphetamines |
| [ ]  Methamphetamines | [ ]  Opioids | [ ]  Tranquillisers |
| [ ]  Non-Opioid Analgesics | [ ]  Heroin | [ ]  Cocaine |
| [ ]  Methadone | [ ]  Buprenorphine | [ ]  Tobacco |
| [ ]  Other (please specify): |  |

**5.2 How do you most commonly administer your main drug of concern?**

|  |  |  |
| --- | --- | --- |
| [ ]  Ingest (swallow) | [ ]  Smoke | [ ]  Inhale (vapour) |
| [ ]  Inject | [ ]  Sniff/Snort | [ ]  Other:  |

**5.3 Did you ever think that your using/drinking was out of control?**

[ ]  Never (or almost never) (0)

[ ]  Sometimes (1)

[ ]  Often (2)

[ ]  Always (3)

**5.4 Did the prospect of not being able to use/drink make you very anxious or worried?**

[ ]  Never (or almost never) (0)

[ ]  Sometimes (1)

[ ]  Often (2)

[ ]  Always (3)

**5.5 How much did you worry about your using/drinking?**

[ ]  Never (or almost never) (0)

[ ]  Sometimes (1)

[ ]  Often (2)

[ ]  Always (3)

**5.6 Do you wish you could stop?**

[ ]  Never (or almost never) (0)

[ ]  Sometimes (1)

[ ]  Often (2)

[ ]  Always (3)

**5.7 How difficult would you find it to stop or go without your drug of choice?**

[ ]  Not difficult at all (0)

[ ]  Quite difficult (1)

[ ]  Very difficult (2)

[ ]  Impossible (3)

**SSDS Score:** 0/**15**

**5.8 Have you ever overdosed?**

[ ]  Yes [ ]  No If ‘Yes’, when did this last happen? *(please provide a date)* Click to enter a date.

**5.9 When did you last use/drink?** *(please provide a date)* Click to enter a date.

**5.10 Are there any other drugs or issues that you are concerned about?**

|  |
| --- |
|  |

**6 General Health**

For each area of your health choose the answer that is right for you now. Your answers will help us work with you to improve your health and **will not impact on your eligibility for the program**.

**6.1 Mobility**

|  |  |
| --- | --- |
| [ ]  I have no problems walking about | [ ]  I have severe problems walking about |
| [ ]  I have slight problems walking about | [ ]  I am unable to walk about |
| [ ]  I have moderate problems walking about |  |

**6.2 Self Care**

|  |  |
| --- | --- |
| [ ]  I have no problems washing/dressing myself | [ ]  I have severe problems washing/dressing |
| [ ]  I have slight problems washing/dressing | [ ]  I am unable to wash or dress myself |
| [ ]  I have moderate problems washing/dressing |   |

**6.3 Usual Activities**

|  |  |
| --- | --- |
| [ ]  I have no problems doing my daily activities | [ ]  I have severe problems with my daily activities |
| [ ]  I have slight problems with my daily activities | [ ]  I am unable to do my usual activities |
| [ ]  I have moderate problems with my daily activities |   |

**6.4 Pain/Discomfort**

|  |  |
| --- | --- |
| [ ]  I have no pain or discomfort | [ ]  I have severe pain or discomfort |
| [ ]  I have slight pain or discomfort | [ ]  I have extreme pain or discomfort |
| [ ]  I have moderate pain or discomfort |   |

**6.5 Anxiety/Depression**

|  |  |
| --- | --- |
| [ ]  I am not anxious or depressed | [ ]  I am severely anxious or depressed |
| [ ]  I am slightly anxious or depressed | [ ]  I am extremely anxious or depressed |
| [ ]  I am moderately anxious or depressed |   |

**6.6 Are you an NDIS client?**

[ ]  Yes [ ]  No

If ‘Yes’, please provide contact details of your NDIS Provider/Support Person:

|  |  |
| --- | --- |
| **Provider:** |  |
| **Support Person:** |  |
| **Email:** |  | **Phone:** |  |

**7 Medical Details**

Having any of the conditions listed below will not impact your eligibility to come to Gindaja. We need this information to ensure that we are able to properly assist you to manage your health conditions.

|  |  |
| --- | --- |
| **Chronic Conditions** | Do you currently have (or have a history of) a chronic medical condition? *(i.e., Diabetes, Heart disease, RHD, Respiratory disease, Kidney disease, Cancer etc.)* [ ]  Yes [ ]  NoIf ‘Yes’, please provide brief details including any current treatment:Click to enter text. |
| Do you have any of the following:[ ]  Hepatitis B[ ]  Hepatitis C[ ]  HIV[ ]  STI[ ]  Other (please specify): |
| **Allergies** | Do you have any allergies? *(i.e., food, medication etc.)* [ ]  Yes [ ]  NoIf ‘Yes’, please provide brief details:Click to enter text. |
| **Medications** | Are you currently taking any medications? [ ]  Yes [ ]  NoIf ‘Yes’, please provide details below: |
| **Condition?** | **Medication?** | **How much?** | **How often?** |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
| **GP** | Do you have a preferred GP? [ ]  Yes [ ]  NoIf ‘Yes’, please provide GP’s name and contact details below: |
| **GP Name:** **Phone:**  |
| **Clinic and Address:**  |

**8 Emotional Wellbeing**

Have you ever had a mental health assessment? [ ]  Yes [ ]  No

If ‘Yes’, please provide diagnosis details (when and where?):

|  |
| --- |
|  |

Below is the K-10 questionnaire. This is a measure of psychological distress (emotional wellbeing). The numbers next to the 10 responses are added up and the total score is the score on the Kessler Psychological Distress Scale. Scores will range from 10 to 50. **Answers to this question will not impact your eligibility to come to Gindaja.**

**Please tick the answer that best describes how you feel.**

|  |
| --- |
| **Kessler (K-10) Psychological Distress Scale** |
| **In the past 4 weeks about how often did you feel…** | All of the time **(5)** | Most of the time **(4)** | Some of the time **(3)** | A little of the time **(2)** | None of the time **(1)** |
| *..tired out for no good reason?* |[ ] [ ] [ ] [ ] [ ]
| *..nervous?* |[ ] [ ] [ ] [ ] [ ]
| *..so nervous that nothing could calm you down?* |[ ] [ ] [ ] [ ] [ ]
| *..hopeless?* |[ ] [ ] [ ] [ ] [ ]
| *..restless or fidgety?* |[ ] [ ] [ ] [ ] [ ]
| *..so restless you could not sit still?* |[ ] [ ] [ ] [ ] [ ]
| *..depressed?* |[ ] [ ] [ ] [ ] [ ]
| *..that everything was an effort?* |[ ] [ ] [ ] [ ] [ ]
| *..so sad that nothing could cheer you up?* |[ ] [ ] [ ] [ ] [ ]
| *..worthless?* |[ ] [ ] [ ] [ ] [ ]
| **Scores:** |  |  |  |  |  |
| **Total Score:** |  |

* *Under 20 Minimal level of distress*
* *20 – 24 Mild level of distress*
* *25-29 Moderate level of distress*
* *30 & over High level of distress*

**9 Medical Approval**

The following must be completed by a qualified GP to certify that you are physically able to participate in Gindaja’s Residential Rehabilitation Program for a 12-week period.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s Name:** |  | **Date of Birth:** | Click to enter a date. |
| **Main Drug of Concern:** |  | **Gender:** |  |
| **Address:** |  |
| **State:** | Choose an item. | **Post Code:** |  |

This letter is to verify that the above mentioned patient has been medically assessed as suitable to participate in an Alcohol and Drug Residential Rehabilitation Program and meets the following criteria (please tick):

[ ]  Is 18 years of age or over

[ ]  Has undertaken appropriate detoxification from Alcohol/Drugs

[ ]  Is physically and psychologically able to participate in daily individual/group AOD rehabilitation activities

**Medical Officer’s Notes**

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Name:** |  | **Date:** |  |
| **Name of Clinic:** |  |
| **Address:** |  |
| **State:** | Choose an item. | **Post Code:** |  |
| **Signature:** |  |

**10 Consent Form**

**Permission to obtain and release personal information**

This form is used to confirm that you consent to your personal and health information being shared by organisations that are supporting or treating you or by government agencies that have relevant information about you that will assist Gindaja in providing you with appropriate treatment and support. We will only disclose your information with other parties that you have agreed to, or where the law allows, or requires it.

|  |
| --- |
| I, (full name): |
| (date of birth): |

Hereby consent to the following information:

* My personal details (e.g., name, contact details, age, gender etc.)
* My health information (e.g., information about my AOD use and my physical & mental wellbeing)
* My criminal history
* Any other information supplied by me or others relevant to my assessment and subsequent participation in Gindaja’s Residential Recovery Program.

Being provided to and received from:

* A Medical Practitioner
* Magistrates and the Department of Justice
* Queensland Police
* Department of Communities, including Child Safety
* Queensland Health
* Legal representatives (i.e., ATSILS)
* Allied Health Professionals
* Other (as listed below)

|  |
| --- |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicants Signature:** |  | **Date:** | Click to enter date. |

**11 Applicant’s Signature**

By signing this application, you:

1. Consent to Gindaja following-up and sharing relevant information with organisations and persons you have mentioned in your application with the understanding that this follow-up and sharing will be specifically and only related to the assessment of your application and your suitability for our service.
2. Consent that any relevant information obtained in the application and assessment process may be used in any subsequent service that may be provided to you by Gindaja.
3. Agree that Gindaja is not in any way legally liable for any issues arising from information requested by Gindaja, that you either did not disclose or did not fully disclose.

|  |  |
| --- | --- |
| **Client Name:** |  |
| **Signature:** |  | **Date:** | Click to enter date. |