Date: ......../……../……..

Dear ……………………………………………………………..

Service provider: ……………………………………………………………………………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: |  | | |
| Gender: | Male / Female | Date of Birth: |  |
| Address: |  | | |
| Contact Number/s: |  | | |

**Consent to share information gained from client: Yes verbal / Yes written / No**

Your client has been accepted into the *XXXXXXX Program* following a referral from: …………………...

**Brief Service Description:**

* Type of Service (e.g. withdrawal, residential recovery, CCCC etc)
* Nature of program client will participate in (for example weekly counselling)
* Timeline for acceptance / commencement of service

**In relation to this client’s condition:**

…………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………….

Waitlist Information: ……………………………………… Admission Date: ………………………………………

We would be grateful if you could please forward any relevant information, which will assist with this client’s care while enrolled in……..*XXXXXX………….*

□ Care Plan

□ Pathology results

□ Other ………………………………………………………

Please do not hesitate to call me if you have any queries.

Yours sincerely,

**Name of clinician**

Role, Service

Phone: ……………………………………………………. Fax: ……………………………………………………….

Email: ……………………………………………………………………………………………………………………….