

Hull Drug and Alcohol Referral Form

Part 1 Screening			
First Name		Surname	
D.O.B.	Ethnicity	Gender <i>M / F</i>	
Address			Post Code
Telephone		Mobile	
GP Details – If Known Name & Address			
Referrer's Details			
Name		Agency	Tel
Address or Stamp			
Do you require feedback re the appointment offered <i>Yes / No</i>			
Substance Use – Please list drugs/alcohol used			
Substance	Prescribed Y/N	Route of use (Sniff, Smoke, Inject, Oral etc)	Length of time used Years/Months
What are the main presenting problems			
Risk and Priority (Please circle any that are known)			
Pregnant	Yes / No	Risk of being harmed by others	Yes / No
Childcare issues	Yes / No	Is a risk to others	Yes / No
Injecting drug use	Yes / No	Homelessness	Yes / No
Ever overdosed	Yes / No	Lives alone	Yes / No
Sexual health concerns	Yes / No	Is under 19	Yes / No
Physical health concerns		Has just been or is about	
Including blood borne viruses	Yes / No	to be released from Prison	Yes / No
Mental health concerns	Yes / No	Criminal behaviour / is involved	
Has self harmed or is talking about self harm	Yes / No	with the criminal justice system	Yes / No
Any additional risks or further information			
Why has the client accessed your service			
Are there any other agencies providing services to the client (that you are aware of)			
Accessibility needs (please Highlight)			
Disabled	Transport	Childcare	Employment
			Translator
Other			
Please briefly expand on:			

Part 2 Referral	
Please make the referral to:	
<p>If alcohol is the main problem:</p> <p style="text-align: center;">Alcohol and Drug Services (ADS) 82 Springbank HU3 1AB Tel: 01482 320606 Fax: 01482 218926</p>	<p>If drugs are the main problem:</p> <p style="text-align: center;">Council for Dependency Problems (CDP) 61 Spring Bank HU3 1AG Tel: 01482 225868 Fax: 01482 580025</p>
If you need any further advice or are unsure about where to refer call CDP – 01482 225868	
Client Consent to be contacted:	
Permission for the treatment agency to contact the client:	
By letter	Yes / No
By phone (Please state which mobile / telephone or both)	Yes / No
Permission to leave a message on:	
Answer-phone	Yes / No
Text Message	Yes / No
Permission for the treatment agency to contact your GP	Yes / No
I consent to:	
Information being shared with referrer about the outcome of my appointment / treatment	Yes / No
Information being shared with my GP about the outcome of my appointment / treatment	Yes / No
The details of this form being sent to the above agency I am being referred to	Yes / No
Consent Statement (to be signed by client)	
I understand that these details will be passed on to one or more of the above agencies for a more detailed assessment to be carried out and that my case may be discussed between them. I am aware that I have requested this referral to be made and that anonymous details will be used to monitor service delivery.	
I understand that the agency I'm being referred to will offer me an appointment by post / telephone and that they will carry out a more in-depth assessment of my needs, however this may not be the agency that provides my treatment if it is felt that another one may be more suitable.	
Client's signature Date	
For Office Use only (please circle as appropriate and feedback to referrer if requested)	
Appointment offered	Yes / No
Appointment information:	
Client:	attended / did not attend
Appointment:	cancelled / rearranged
Advice / Information given	Yes / No
Priority status (circle)	
High	= 3
Medium	= 2
Low	= 1