Recovery Near You Single Point of Contact Referral Form ☎0300 200 2400

Referral to service: Adult Alcohol ☐ Adult Drug ☐ Young People ☐ Referral Date:

Patient Details	Referrer Details
Mr/Mrs/Miss/Ms	Referrer Agency:
Name:	Referrer Name: Referrer Role:
Address: Post Code:	Referrer Address: Post Code:
Preferred Tel Number:	Referrer Tel No: Fax No:
DOB: Sex: M ☐ F ☐	Referrer e-mail:
Patient consent to referral : Y☐ N: ☐ Patient consent be contacted via: (please tick) Telephone/mobile: ☐ Post: ☐ Email: ☐ Referrer:☐	GP Name & Surgery (if known): Practice Tel No (if known):
Ethnicity: Religion:	Details of any prescribed medication and dosage:
Occupation: JSA/ ESA/Universal Credit/ other: Full Time Y ☐ N ☐ Do they drive: Y☐ N ☐	Details of hearing, visual, physical/ mental health difficulties
Is patient motivated? Y ☐ N☐	

Interpreter required? ☐ Please state language, incl. sign language:

Social History: Carer with dependents Y ☐ N☐ No. children under 18 living with patient

Any other agencies involved?

Reason for Referral

(Adults) Audit Score

Alcohol units weekly

Drug amount used weekly (£/weight)

No. of Hospital Admissions in last 12 months

Substance Type:

- ☐ Alcohol
- ☐ Amphetamine
- ☐ Benzodiazepines
- ☐ Cannabis
- ☐ Cocaine
- ☐ Crack
- ☐ Ecstasy
- ☐ Heroin
- ☐ Ketamine
- ☐ Methadone
- ☐ NPS
- ☐ Subutex/Buprenorphine
- ☐ Solvents
- ☐ Other _____

Pattern of misuse in last 28 days:

- ☐ Daily
- ☐ 2-6 x weekly
- ☐ Fortnightly
- ☐ Not in last month

- ☐ Smoke
- ☐ Oral
- ☐ Inject
- ☐ Sniff
- ☐ Other

Social Circumstance:

- ☐ NFA
- ☐ Living with others
- ☐ Lives alone
- ☐ Support at home

Risk Assessment:

- ☐ Currently Injecting?
- ☐ Severe Mental Health Problems
- ☐ Suicide/Self Harm Risk
  - ☐ Present
- ☐ Violence/ Aggression
- ☐ Safeguarding/Vulnerable

Risk Details:

Email: bsmhft.recoverynearyou@nhs.net (secure email) Fax: 01902 504011
Post: Recovery Near You, 5-9 Pitt Street, Wolverhampton, WV3 0NF

*** INCOMPLETELY FILLED REFERRAL FORMS MAY DELAY ASSESSMENT OF YOUR PATIENT ***