|  |
| --- |
| **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: Full Time Y [ ]  N [ ]  Do they drive: Y[ ]  N [ ]  | JSA/ ESA/Universal Credit/ other: | **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/VulnerableRisk Details:       |
|  |
|  |
| **Email:** **bsmhft.recoverynearyou@nhs.net** **(secure email) Fax: 01902 504011** **Post: Recovery Near You, 5-9 Pitt Street, Wolverhampton, WV3 0NF** |
|  |