**Referral Form**

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| **Details** | | | | | |
| Name |  | NHS No |  | DOB |  |
| Address |  | Telephone |  | | |
| GP |  |  |  | | |
| Nationality |  | Ethnicity |  | | |
| Gender |  | Sexuality |  | | |
| Religion |  |  |  | | |
| Keyworker  Name  Email  Tel |  | Referring Team & email |  | | |
| NOK/ Emergency Contact |  |  |  | | |
| Any dates to be avoided/not available? | |  | | | |

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| **REFERRAL CHECK LIST** | | | | | | | | | | | | | | | | | | | | | | |
| FORM COMPLETED | | | | | | | | | |  | | | | | | | | | | | | |
| RECENT BLOODS ATTACHED [(click here for form)](https://www.inclusion.org/wp-content/uploads/2023/02/Blood-test-request-letter.docx) | | | | | | | | | |  | | | | | | | | | | | | |
| RECENT GP SUMMARY ATTACHED | | | | | | | | | |  | | | | | | | | | | | | |
| CLIENT CONSENT ATTACHED | | | | | | | | | |  | | | | | | | | | | | | |
| SENIOR REVIEW | | | | | | | | | |  | | | | | | | | | | | | |
| Are there any upcoming appointments/ dates that client would not be available? | | | | | | | | | |  | | | | | | | | | | | | |
| The INFORMATION BOOKLET and VIDEO can be found here  [Referring to Dame Carol Detoxification Service - Inclusion](https://www.inclusion.org/ipu-referrals/) | | | | | | | | | |  | | | | | | | | | | | | |
| **Treatment requested** | | | | | | | | | | | | | | | | | | | | | | |
| **DETOXIFICATION** | | | | | | | | | | | **STABILISATION** | | | | | | | | | | | |
| **Substance misuse (NDTMS)** | | | | | | | | | | | | | | | | | | | | | | |
| Ranking | | | Substance | | | | | Route | | | | | | | Frequency | | | | Amount | | | |
| 1 | | |  | | | | |  | | | | | | |  | | | |  | | | |
| 2 | | |  | | | | |  | | | | | | |  | | | |  | | | |
| 3 | | |  | | | | |  | | | | | | |  | | | |  | | | |
| Age first used (primary substance only) | | | | | | | | | | | | | | | | | | | |  | | |
| **Alcohol use (current)** | | | | | | | | | | | | | | | | | | | | | | |
| Describe | | | | | | | | | | | | | | | | | | | | | | |
| Units/Day | |  | | | | Days drinking in last 28 | | | | | |  | | | | SADQ  [(click here for form)](https://www.inclusion.org/wp-content/uploads/2022/04/App_F_SADQ.doc) | | | | |  | |
| **Drug use (current)** | | | | | | | | | | | | | | | | | | | | | | |
| **Drug** | | | | **Amount** | | | | | | | | **Route** | | | | | | **Frequency** | | | | |
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| **Prescription (Substance misuse)** | | | | | | | | | | | | | | | | | | | | | | |
| **Drug** | | | | | | | **Dose** | | | | | | | | | **Dispensing** | | | | | | |
| **Community pharmacy details** | | | | | | |  | | | | | | | | |  | | | | | | |
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| **Urine drug screen (recent)** | | | | | | | | | | | | | | | | | | | | | | |
| Date | Amphetamine | | | | Cocaine | | | | EDDP/  Methadone | | | | | Opiate Screen | | | Benzodiazepines | | | | | Buprenorphine |
|  |  | | | |  | | | |  | | | | |  | | |  | | | | |  |
| **Treatment history** | | | | | | | | | | | | | | | | | | | | | | |
| Including previous detoxifications  Any history of Delirium Tremens or alcohol withdrawal seizures | | | | | | | | | |  | | | | | | | | | | | | |
| **Contingency plan and post detoxification plan** | | | | | | | | | | | | | | | | | | | | | | |
| If there is a plan for a service user to go to dry housing or secondary rehabilitation on successful completion, please include a contingency plan in the event the detoxification is not completed. | | | | | | | | | | | | | | | | | | | | | | |
| **Smoking** | | | | | | | | | | | | | | | | | | | | | | |
| **DCDS is a non-smoking environment.**  Smoking status:  Residents may vape in the garden, and we can also provide Nicotine Replacement Treatment – patches, inhalators and lozenges.  Service user aware | | | | | | | | | | | | | | | | | | | | | | |
| **CHILDREN** | | | | | | | | | | | | | | | | | | | | | | |
| Children under the age of 18? | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| If no move on to next section | | | | | | | | | | | | | | | | | | | | | | |
| Are the children resident with service user? | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Does the service user have parental responsibility? | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Please give details if any additional support for children is in place: | | | | | | | | | | | | | | | | | | | | | | |
| No additional support in place | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Early Help | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Child in need | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Child protection plan | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Looked after child | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Declined to answer | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Is service user pregnant?  Yes  No | | | | | | | | | | If pregnant – estimated date of delivery. | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | |
| **Accommodation:** | | | | | | | | | | | | | | | | | | | | | | |
| **Employment status:** | | | | | | | | | | | | | | | | | | | | | | |
| **Covid 19 vaccination status** | | | | | | | | | | | | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | |
| **Please ensure service users who are alcohol dependent are taking Thiamine 100mg three times a day prior to admission.** | | | | | | | | | | | | | | | | | | | | | | |
| **Physical health** | | | | | | | | | | | | | | | | | | | | | | |
| Current medical issues. Please provide relevant medical notes**.** | | | | | | | | | | | | | | | | | | | | | | |
| **Mental health** | | | | | | | | | | | | | | | | | | | | | | |
| Current mental health e.g. depressed mood, suicidal ideation, psychosis | | | | | | | | | | | | | | | | | | | | | | |
| **Open to mental health services?** Please give details of care coordinator and service | | | | | | | | | | | | | | | | | | | | | | |
| **Forensic history** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Safeguarding concerns** please give details | | | | | | | | | | | | | | | | | | | | | | |
| **Adult** | | | | | | | | | | | **Children** | | | | | | | | | | | |
| **Risks** | | | | | | | | | | | | | | | | | | | | | | |
| Risk to self | | | | | | | | | | | | |  | | | | | | | | | |
| Risk from others | | | | | | | | | | | | |  | | | | | | | | | |
| Risk to others | | | | | | | | | | | | |  | | | | | | | | | |
| Care & Support Needs | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have any disabilities? Please give details** | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have mobility issues or difficulties with personal care?** | | | | | | | | | | | | | | | | | | | | | | |

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| **BBV details** | | |
| **Not applicable to ask** | | |
| Hep B status: | Choose an item. | |
| Hep B vaccination status | Date of vaccination 1: | |
| Date of vaccination 2: | |
| Date of vaccination 3: | |
| Date of booster: | |
| Date of last hep C test |  | |
| Hep C status: | Choose an item. | |
| Previous hep C treatment | Yes: | No: |
| H.I.V. status | Choose an item. | |
| **Injecting status**  Currently injecting  previously injected  Never injected | | |
| Injected in last 4weeks  Ever shared needles  Referred to hepatology | | |

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| **Client statement and consent** | |
| Why are you requesting detoxification at this time? | |
|  | |
| I agree for my data to be shared with NDTMS |  |
| I consent to my information being shared between services as required to ensure my safe care. |  |
| Date | Signature |
| Witness |  |