**Referral Form**

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

|  |
| --- |
| **REFERRAL CHECK LIST** |
| FORM COMPLETED |[ ]
| RECENT BLOODS ATTACHED [(click here for form)](https://www.inclusion.org/wp-content/uploads/2025/09/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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Prescription (Substance misuse)** |
| **Drug** | **Dose** | **Dispensing** |
| **Community pharmacy details** |  |  |
|  |  |  |
| **Urine drug screen (recent)** |
| Date | Amphetamine | Cocaine | EDDP/Methadone | Opiate Screen | Benzodiazepines | Buprenorphine |
|  |  |  |  |  |  |  |
| **Treatment history** |
| Including previous detoxificationsAny 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?** |

|  |
| --- |
| **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 [ ]  |

|  |
| --- |
| **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 |  |