**WDP - INROADS - Camden Referral Form**

|  |  |
| --- | --- |
| Referral Date |  |

**Referrer Details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Agency Name |  | Worker Name | | |  | | |
| Agency Type |  | | | | | | |
| Agency Address |  | | | | | | |
|  | | | | | Postcode |  |
| Telephone |  | | Fax |  | | | |
| Email |  | | | | | | |
| Reason for Referral |  | | | | | | |

**Service User Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | | First Name | | |  | | | | | | | | Last Name | | | |  | | | | | | |
| NHS No. |  | | | | | | N.I. No. | | |  | | | | | | Date of Birth | | | |  | | | | |
| Address |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Post code | |  | | | | | | | | | | Can we contact service user at this address? | | | | | | | Yes | |  | | No |  |
| Landline number | |  | | | | | | | | | | Can we contact service user on this number? | | | | | | | Yes | |  | | No |  |
| Mobile number | |  | | | | | | | | | | Can we contact service user on this number? | | | | | | | Yes | |  | | No |  |
| Email Address | |  | | | | | | | | | | Can we contact service user on this e-mail? | | | | | | | Yes | |  | | No |  |
| Client Gender | | Male | |  | Female | | |  | Not known | |  | | Not specified | |  | | Ethnicity  (specify) | | | | |  | | |
| Housing Needs | | Specify current living situation- None | | | | | | | | | | | | | | | | | | | | | | |

**Permission to share my information with my local Substance Misuse Service for follow up support**

**Y/N …......... Date ………….. Signed…………………………………………….. Verbal Consent…………………..**

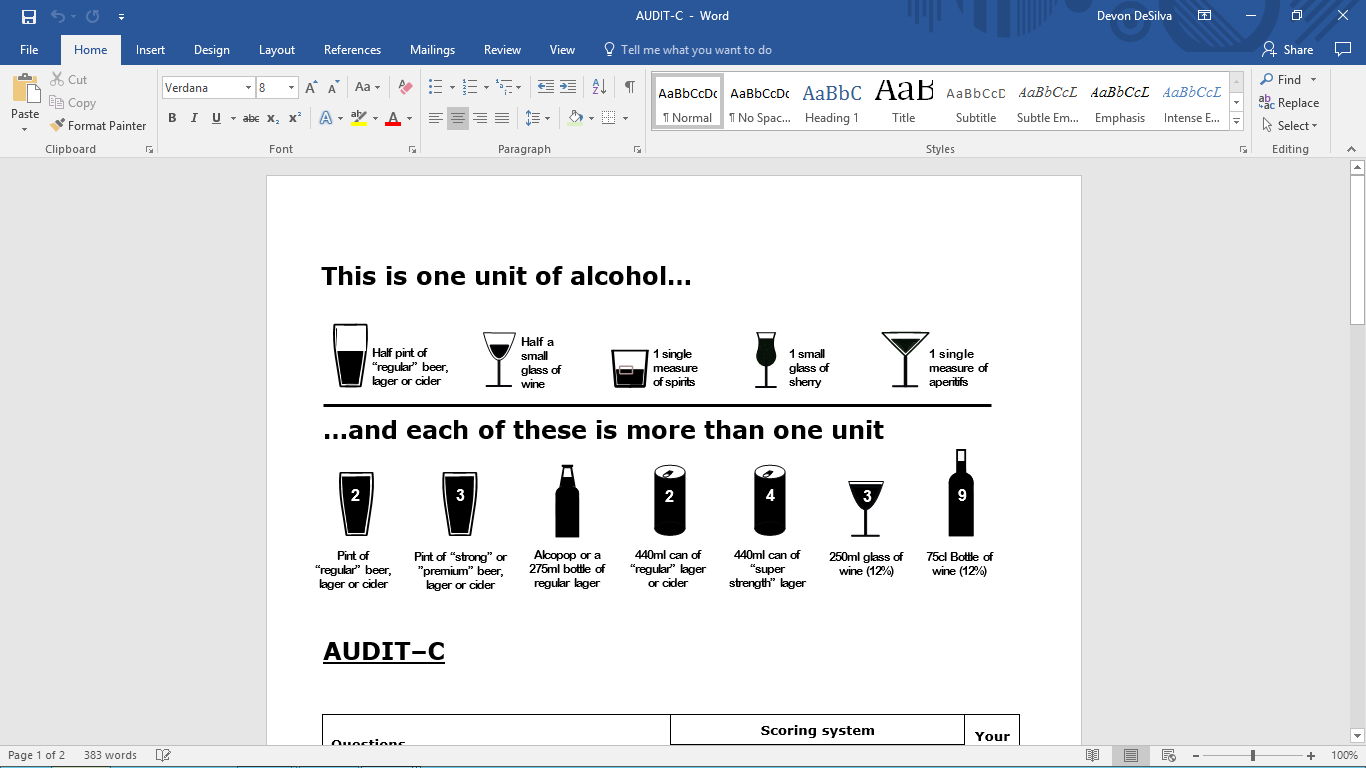
|  |  |  |  |
| --- | --- | --- | --- |
| GP Surgery Name |  | Address |  |
| Postcode |  | Telephone Number |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does the service user understand spoken English? | Yes |  | No |  | Does the service user understand written English? | | | Yes |  | No |  |
| Is an Interpreter needed? | Yes |  | No |  | If yes, please specify language: |  | | | | | |
| Does the service user have a Physical Disability? | Yes |  | No |  | Please provide details of support that may be required for the client to access the service: | |  | | | | |

**Supporting Access to Services**

**Substance Misuse**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Drug name** | **Frequency of use** | **Method of use if known**  **(smoke/inject/ingest)** |
| **Primary substance** |  |  |  |
| **Secondary substance** |  |  |  |



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT-C** | | | | | | |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly  or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| **Scoring**  A total of 5+ indicates increasing or higher risk drinking.  An overall total score of 5 or above is AUDIT-C positive. | **AUDIT-C Score** | | | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pregnancy |  | Safeguarding Children / Childcare Concern | |  | Injecting Drug Use |  |
| Physical Health Concerns |  | Safeguarding Adult Concern | |  | Suicide Risk |  |
| Mental Health Concerns |  | Domestic Abuse | |  | In Prison Custody |  |
| Homelessness |  | Other (please specify): |  | | | |
| Are there any other risk concerns to note? | | | | | | |

**Risk Screen**

**Please return via email:**

**Email:** [INROADS.Camden@viaorg.uk](mailto:INROADS.Camden@viaorg.uk) **Secure email:** [INROADS@cjsm.net](mailto:INROADS@cjsm.net)

**For any queries, please contact us on:**

Tel: 0300 303 4545

**For Via INROADS Camden use only**

Date referral received: ……………………………………………………………… Referral received by: …………………………………………………………….

Nebula No.: ………………………………………………………………………………. Allocated:……………………………………………………………………………...