**Via - New Beginnings – Brent Referral Form**

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| --- | --- | --- | --- | --- | --- | --- |
| Has the client given consent for the referral? | Yes |  | No |  | Client signature (if applicable) |  |

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| **Referrer Details** (if applicable) |
| Agency Name |  | Worker Name |  |
| Agency Type  |  |
| Agency Address |  |
|  | Postcode |  |
| Telephone |  | Fax |  |
| Email |  |

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| **Service User Details** |
| Title  |  | First Name  |  | Last Name  |  |
| Date of birth  |  | Ethnicity  |  |
| Client Gender  | Male  |  | Female |  | Transgender  |  | Not specified |  |
| 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 |  |

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| **Substance Misuse** |
|  | Drug name | Frequency of use | Method of use(smoke/inject/ingest) |
| Primary substance |  |  |  |
| Secondary substance  |  |  |  |
| Tertiary substance  |  |  |  |

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| **Supporting Access to Services** |
| 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: |  |

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| **Risk Screen** |
| Pregnancy  |  | Safeguarding Children  |  | CIN |  | CPP |  | Safeguarding Adult Concern  |  |
| Physical Health Concerns  |  | Injecting Drug Use |  | Suicide Risk  |  |
| Mental Health Concerns |  | Violent Forensic history  |  | In Prison Custody |  |
| Neglect |  | Domestic Abuse  |  | Sex worker |  |
| Homelessness |  | With probation (PO name) |  |  | Other please specify |  |
| Are there any other risk concerns to note? |

**NOTE FOR PROFESSIONALS:** Please attach anyadditional information that may be helpful, such as recent CPA documentation, summary of care or risk assessment

**Please return via post, email or fax:**

New Beginnings |97 Cobbold Road | Willesden | London | NW10 9SU

New Beginnings | Willesden Centre for Health| Harlesden Road| Willesden | London | NW10 3RY

**Email:** info.brent@viaorg.uk

**Secure email:** info.brent@wdp.cjsm.net

**E- Fax:** 03333444658

**For any queries please contact us at:**

Tel: 03003034611

For Via use only

Date Referral was Received: ……………………………………

Referral Received by: ……………………………………………….

Client Nebula No: …………………………………………………….