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

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

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

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

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: |  | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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](mailto: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: …………………………………………………….