**Via - West Berkshire Adult Drug and Alcohol Service: 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 | Monthlyor 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**  |  |

**Risk Screen**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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? |

**Please return via post or email:**

**Address:** 1 Station Road, Newbury, RG14 7LP

**Email:** west.berkshire@viaorg.uk

**Secure email:** west.berkshire@wdp.cjsm.net

**For any queries, please contact us on:** 0300 303 4554

**For Internal use only**

Date referral received: ………………………………………………………………

Referral received by: …………………………………………………………….

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