Referral Form

Signpost Services / Addiction Recovery Service / Addictions Support & Counselling Services

Details of person referred

Forename:

Surname:

Address:

Postcode:

Date of birth:

❑Male ❑Female

Telephone number (if known):

Mobile number (if known):

Email (if known):

Chi number (if known):

Is client aware of referral? ❑ Yes ❑ No

Served in the armed forces ❑ Yes ❑ No

Pregnant ❑ Yes ❑ No

Carer ❑ Yes ❑ No

Learning disability ❑ Yes ❑ No

Nationality:

Ok to send mail/text/email ❑ Yes ❑ No

Ok to call/leave message ❑ Yes ❑ No

❑ **SMR25a completed on assessment**

❑ **SMR25a No: ……..**

❑ **SMR25b completed on the point of referral and SDMD website updated**

What is the reason for this referral?

- ❑ Early Intervention / Harm Reduction
- ❑ Substitute Prescribing
- ❑ Detoxification
- ❑ CBT Counselling
- ❑ Community Rehabilitation
- ❑ Family Support
- ❑ Other (please specify)

Details of referrer

Referrer's Name:

Designation:

Name of referring Organisation/Service:

Address:

Postcode:

Tel No:

Email address:

Wish to be kept informed ❑ Yes ❑ No

Date of referral:

Referral Source

Direct Referral
- ❑ Self
- ❑ Carer/Relative/Friend

Social Work/Justice Services
- ❑ SW Community Care
- ❑ SW Justice Service
- ❑ SW Children/Families
- ❑ SW Early Intervention
- ❑ SACRO
- ❑ Prison Service
- ❑ Police

Health Services
- ❑ GP
- ❑ Other Doctor
- ❑ Psychological Services
- ❑ Psychiatric Services
- ❑ Health Visitor
- ❑ CPN
- ❑ Other Nurse
- ❑ Community MH Services
- ❑ Other MH Services

Employment Services
- ❑ Employer
- ❑ Employment Services

❑ **Internal Referral**

Addiction Services
- ❑ Addictions Recovery Service (ARS)
- ❑ Addictions Support & Counselling (ASC) - FV
- ❑ Addictions Treatment Service (DTTO)
- ❑ HAT Team
- ❑ Signpost Services
- ❑ Substance Misuse Team (CADS)
- ❑ Substance Misuse Children Service
- ❑ Young People Connect Service
- ❑ Young People Freaggarach Service

Other / Miscellaneous
- ❑ SSAFA
- ❑ Social Prescription
- ❑ Housing or Homeless Services
- ❑ Family Support Services
- ❑ Other (Please Specify)

Presenting problem:

❑ **Own Alcohol** ❑ **Own Drug/s** ❑ **Own Alcohol & Drugs** ❑ **Own Gambling**
❑ **Other's Alcohol** ❑ **Other's Drug** ❑ **Other's Alcohol & Drugs** ❑ **Other's Gambling**
❑ **Other** _____

Notes:

Date of recent substance misuse:

Current Substitute Prescription (if any):

Previous Contact with addictions services

Name of the service	**Year**
❑ Addiction Recovery Service (ARS)	
❑ Addictions Support & Counselling (ASC)	
❑ Addictions Treatment Service (DTTO)	
❑ HAT team	
❑ Signpost	
❑ Substance Misuse Service (CADS)	
❑ Substance Misuse Children Service	
❑ Young People Connect Service	
❑ Young People Freaggarach Service	
❑ AA/NA/CA	
❑ Residential Rehab	
❑ GPPS	
❑ Other (Please specify)	

Current Contact with other Addiction services excluding the referring organisation

Name of the service:

Name of the worker:

Notes: (interventions delivered ie, detox, ABI, Naloxone…etc)

Areas of risk: (if known)

❑ Responsible for children
❑ Pregnancy (due date…….)
❑ Domestic Abuse
❑ Violence/Aggression
❑ Homeless/or risk of
❑ Recently liberated from custody
❑ Due to be liberated from custody
❑ Challenging behaviour
❑ Currently injecting
❑ Sharing injecting equipment
❑ Self harm/injury
❑ Other

Was Risk assessment completed? ❑ Yes ❑ No ❑ Not known
(if Yes, please specify and/or please provide any relevant reports e.g. SER, Risk assessment etc)

Any relevant diagnosed physical / mental health problems (e.g. disabled, poor mobility, psychosis, other accessibility issues etc)?

GP Name:

GP Telephone Number:

GP Surgery & Address

Legal status (if known)

❑ **None**	❑ **Parole licence**	❑ **Bail condition**
❑ **On probation**	❑ **Non-parole licence**	❑ **Unknown**
❑ **On probation with condition to attend**	❑ **Pending case/s**	❑ **HDC** (Home Detention Curfew)
❑ **Diversion from prosecution**	❑ **Awaiting sentence**	❑ **Other (please specify)**

Where/How did you hear about our services?

Children under the age of 18 with whom the service user has contact with/cares for: ❑ **Yes** ❑ **No**
If Yes please specify below

Child(ren)'s full name/s	Age/Date of Birth	Address if different from SU's address

Please provide any other relevant information, including:

- **Brief history of problem**
- **Involvement of other universal services**
- **Housing situation**
- **Is the service user ready to engage with our services**
- **What does the service user hope to achieve from accessing our services**

Please use separate blank sheet if required
The completed referral should be sent one of to the following secure email addresses:

FV-UHB.SignpostRecovery@nhs.net asc.fk@nhs.net

Office Use Only

Service User Name:	DOB:	❑ Entered on Database **Local Reference Number:**
Date referral received:	❑ Accept ❑ Request further information	❑ Reject: No action required ❑ Reject: Transfer to another service
❑ New referral ❑ Re-referral within 6 months ❑ Re-referral out-with 6 months	Allocated to: Allocated by: Date allocated:	Reason: Date of Transfer: Name of the service transferring to:
Received/Transcribed by:	Initial contact made with service user: ❑ Yes ❑ No Letter required: ❑ Yes ❑ No Date letter sent to Service user:	Unavailable for assessment from date: Unavailable to:
SMR Data: ❑ SMR not required ❑ SMR a is required ❑ SMR b notification is expected SMR Reference Number: ❑ SMR a data entry date: ❑ SMR b data entry date: ❑ SMR closure data entry date:	Date of first appointment and/or assessment Discharge Date: Discharge Information:	Unavailability reason: ❑ Criminal Justice ❑ Medical ❑ Social Waiting Time Data: ❑ Waiting Time not required ❑ Waiting Times data entered ❑ Waiting times Reference Number: ❑ Initial Waiting Times data entry date: ❑ Closure Waiting Times data entry date:
Additional Notes		