#

# Cambridgeshire Drug and Alcohol Recovery Services Referral Form

|  |  |
| --- | --- |
| **Telephone:** | **Tel: 0300 555 0101** |
| **Fax Referrals:**  | **Fax:**  |
| **Postal Referrals:** | **CGL Mill House, 351 Mill Road, Brookfield Hospital site, Cambridge CB1 3DF** |
| **Email referrals:** | **Cambridgeshire1@cgl.cjsm.org.uk** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **DOB:** | **Marital status:**  |
| **Gender:** |  | **Contact number 1:** | **Next of kin details**:*Address/telephone number /relationship* |
|  |
| **First language** |  | **Contact number 2 :**  |
|  |
| **Address/place of contact:****Sofa surfing / rough sleeping give details**  |   |
| **Nationality:** |  | **Disability: give details** |
| **Ethnicity :** |  |
| **GP (name, address and****Telephone number if****Known):** |  |
| **Nature of substance****Misuse / Reason for referral** **Alcohol: frequency / type /percentage (audit score )****Drug: Substance / How much/ Frequency/ Weekly Spend/ route of administration – injecting / smoking / snorting****Family intervention from Family Co-ordinator to address parenting and impact of substance of misuse on parenting.** |  |
| **Physical health issues:**Diagnosis / Medication | **Diagnosed :**  | **Medication :**  |
| **Diagnosed :** | **Medication :** |
| **Diagnosed :** | **Medication :** |
| **Diagnosed :** | **Medication :** |
| **Mental Health :**Give details of self-diagnosed/ self-harming / suicidal ideation/prescribed medication and dates if known. Record professionals involved – Eg CPN / GP / Psychiatrist / Consultant  |  |
| **Known Risk to self or others:**Sex working /Vulnerable Adult / History of / current DV / MAPPA / MARAC / self-harm / SuicideAreas you are concerned about |  |
| **Personal circumstances:****Children Under 18 :**Relationship Status / Housing / Employment. Any children under 18? Where present, give details of children, Health Visitor, Midwife, Social worker / CP / CIN details. Are you a carer or cared for /ex service personnel? |  |
| **Other agencies worked****with:**Probation/ CMHT/ children services | **Past:** |  |
| **Present:** |  |
| **Offending history:** *give details*  |  |
| **Additional Information:** |  |
| **Referred to Aspire by:** |  | **Agency:** |  |
| **Contact number:** |  | **Date:** |  |
| **Does Client consent to this referral? Yes/No** |  | **Referral taken / received by :** Internal  |
|  |