REFERRAL TO SOUTHAMPTON SUBSTANCE USE TREATMENT SERVICES

Does patient require any assistance or support? (eg User Group/Community/ representative/interpreter)

NHS No.......................... Title Ms Miss Mrs Mr Other.........

(1) Forename(s) .... **(2)** Surname/Family Name...

(4) Gender M / F **(3)** Date of birth

(5) Ethnicity.................................(see guidelines) 1st language...

Address..

(13) Post code..............................Phone No(s)..

Next of Kin Details(Optional)..

Permission to contact NOK **YES/NO** Permission to leave messages **YES/NO.**

GP name/initials... Phone No...

Surgery..

SUBSTANCES USED (Please indicate primary / secondary / tertiary problem)

HEROIN		METHADONE		SUBUTEX		BENZODIAZEPINES	
AMPHETAMINES		COCAINE		CRACK COCAINE		ECSTASY	
CANNABIS		SOLVENTS		other drug		ALCOHOL	

Are any of these being injected? If so, which? ....

AGENCIES INVOLVED		Name of worker	Contact No
MENTAL HEALTH	**YES** / **NO**	....	
PROBATION SERVICE	**YES** / **NO**	....	
SOCIAL SERVICES	**YES** / **NO**	....	
HEALTH VISITOR	**YES** / **NO**	....	
CHILDEN/FAMILIES TEAM	**YES** / **NO**	....	
USER GROUP/ADVOCACY	**YES** / **NO**	....	

OTHER..

If there is any known TREATMENT history, please give details ....
....

If there are any known PHYSICAL HEALTH issues, please give diagnosis or symptons......................
....
....

Has patient been tested/vaccinated for Hep B? **YES** / **NO** / **NOT KNOWN**

If there are any known MENTAL HEALTH issues, please give diagnosis or symptons.........................
....

Please give a reason for this REFERRAL and say what treatment it is the patient seeks...................
....
....

List any RISKS to self or others. Please include any PRIORITY factors (see guidelines)
....
....

(7)(22) Details of referrer – either SELF REFERRAL or REFERRAL AGENCY/NAME.................................
....

Has patient been given a copy of this form? **YES** / **NO** / **DECLINED**

Has the patient given consent to the information in this referral being sent to a specialist drug/alcohol treatment provider? **YES** / **NO**

Signature of service user.. **(6)** date of referral ....
(where possible)

FOR OFFICE USE IN TIER 2/3 TREATMENT SERVICE

(Please record all core data from the referral, and the following information)

(15) DAT of residence.. **(16)** PCT of residence...

(47) Local Auth .... **(8)** Client reference no

Date referral received in T 2/3 ....**(22)**Referrers Agency Code ....