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# Cambridgeshire Drug and Alcohol Recovery Services Referral Form

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| **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**](mailto:Cambridgeshire1@cgl.cjsm.org.uk) |

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| --- | --- | --- | --- | --- | --- |
| **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 :** |
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| **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 / Suicide  Areas 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 | |
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