Referral Form

All items should be completed to ensure Appropriate, Safe and Timely assessment and substance misuse detoxification. Please contact BAC O'Connor (01283 537280) if you have problems completing this form.

The completed form should be returned to BAC O'Connor on facsimile: 01283 545239, for the attention of the Assessment team

Referrer					
Date of Referral			**Name of Referrer**		
Contact Numbers			**Referring Organisation**		
Treatment Required	**Detoxification**	☐	**Rehabilitation**	☐	**Detoxification and Rehabilitation** ☐

Client Details						
Client ID						*Allocated by BAC O'Connor*
Forename						*As recorded on client's birth certificate*
Family Name						
Gender	Female	☐	Male	☐		*Gender of the client at time of screening*
Date of Birth						*day month year, e.g. 27 May 1966*
Nationality	UK ☐ Other, state: ☐		*Includes: England, Scotland, Wales and Northern Ireland.*			*Country of residence at birth*
Ethnicity ***tick <u>one</u> option***	White British ☐ White/Black African ☐ White/Black Caribbean ☐ White & Asian ☐ Other Mixed ☐ Not Disclosed ☐		White Irish ☐ African ☐ Caribbean ☐ Chinese ☐ Other Black ☐ Other, state: ☐		Other White ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian ☐	
First Language	English ☐ Other, state: ☐		Translation/interpreter needed? Yes ☐ No ☐ Makaton Sign language? Yes ☐ No ☐			
Sexuality *tick <u>one</u> option*	Heterosexual ☐ Bi-Sexual ☐		Homosexual ☐ Not Disclosed ☐			
Is the client pregnant?	No ☐		Yes ☐			Estimated delivery date: ……

Bn

BAC O'Connor Referral Form

Client Contact Details			
Contact Address		**Is the address:**	
		Home residence	☐
		Prison	☐
		Temporary	☐
		Squat	☐
Postcode		No Fixed Abode	☐
Contact Telephone	Mobile:	Landline:	

GP Details	
Name	
Address	
Postcode	
Telephone	

Other Professionals	
	Details of other professionals involved with client, such as SW, CPN, etc.
Name & Role	
Organisation	
Address	
Postcode	
Telephone	
Name & Role	
Organisation	
Address	
Postcode	
Telephone	
Name & Role	
Organisation	
Address	
Postcode	
Telephone	
Name & Role	
Organisation	
Address	
Postcode	
Telephone	

Medical Issues

Current Medical Conditions		
Allergies Please list any know allergies		
Current Medication		**Declaration** I (referrer) …… confirm that the client is actively taking the above drugs. I confirm they have collected a prescription for their current medication in the last 28 days. I confirm the client is aware and been informed they need to bring at least 2 weeks supply of medication prescribed via GP when admitted.
Past Medical History		
BBV	Hepatitis B	Vaccinated? Yes ☐ No ☐ Infected? Yes ☐ No ☐
	Hepatitis C	Tested? Yes ☐ No ☐ If YES, Positive? Yes ☐ No ☐ Date of last test:
	HIV	Date tested: Result +ve ☐ -ve ☐
	Any Current STDs	Yes ☐ No ☐ Treatment:
Neurological issues		

Mental Health

Past/current mental health issues	Include in-patient and community treatments
Has the person ever experienced any of the listed problems either in the past or currently – please provide a brief overview	Self-harm ☐ Suicide attempts ☐ Suicidal ideation/ plans ☐ Depression ☐ Anxiety Disorder ☐ Bi-polar disorder ☐ OCD ☐ Psychotic Episodes ☐ Self-neglect ☐ Cognitive impairment ☐ Personality Disorder ☐ Asperger's Syndrome ☐ Learning Difficulties ☐ Admissions under the Mental Capacity Act ☐ Other mental health issues ☐ Please explain any of these issues below
Mental Capacity/safeguarding issues	In line with the guidelines set in the Mental Capacity Act does the person have Full capacity ☐ Fleeting Capacity ☐ Please explain the rationale for the above:
	Are the any safeguarding issues? Yes ☐ No ☐
	If so, please explain
Forensic History	Violence to others Yes ☐ No ☐ Exploitation / Harm to others Yes ☐ No ☐ Arson/Attempted Arson Yes ☐ No ☐ Sexual Offences Yes ☐ No ☐ Schedule One Offences Yes ☐ No ☐ Other Yes ☐ No ☐ Any pending Yes ☐ No ☐
	If yes, Please provide details

Substance Use

Primary Substance						*For which Detox is required.*
Age first Used			*(years)*			*Age when Primary Substance first used*
How Primary Substance Administered	Inject ☐ Sniff ☐ Other, state: ☐			Oral ☐ Smoke ☐		*Method by which Primary Substance taken, tick main method only.*
Injecting Status	Never Injected ☐ Previously Injected ☐			Currently Injecting ☐ Declined to answer ☐		*Tick one option.*
Injected in Last 28 days	No ☐			Yes ☐		*Tick one option.*
Ever Shared Equipment	No ☐			Yes ☐		*Refers to Injecting equipment only, tick one option.*
Days Drinking in Past 28			*(days)*			*Number of drinking days in the 28 days prior to referral.*
Units of Alcohol			*(units)*			*Average number of units consumed on a drinking day.*
Other Substances Used						*List all substances used in past 28 days and how administered.*
Most recent test results	Alcohol		Date:			*Please list the most recent drug screens and/or alcometer reading*
	Opiates		Date:			
	Methadone		Date:			
	Benzodiazepines		Date:			

Substance Use History *(Brief overview of key facts)*

Previous Detoxifications *(Details of any previous Detox, to include date, method, if completed, and any adverse reactions)*

Withdrawal Complications *(Complications the client has experienced during previous withdrawals/detoxifications)*

Withdrawal Seizures ☐ DT's ☐

Details: *(Please provide details, including whether the client was medically supervised at the time)*

Detoxification requirements			
Alcohol Detoxification	14-21 days ☐		7-10 days ☐
Opiate Detoxification	Person prefers to detoxify using: Methadone ☐	Subutex ☐	Lofexidine ☐
Benzodiazepine detoxification	Diazepam ☐	Other ☐ Please state: Planned admission dose:	
Stimulant detoxification	Yes ☐	No ☐	*i.e. Symptomatic relied offered in preparation for rehab programme*
Dual Detoxifications Note: Alcohol will always be managed first	Opiates and Alcohol ☐	Alcohol and Benzodiazepines ☐	Opiates and Benzodiazepines ☐
	Other combination ☐	Please state:	
Other	Please identify any other medications that may need to be addressed such as (non-prescription) Pregabalin, Gabapentin, etc		

Transport	
Details of transport arrangements to and from BAC O'Connor	*N.B. Where possible BAC would prefer the client should be accompanied to minimise risk of 'last chance' substance misuse, and particularly post-detox accidental overdose*

Other
Any other relevant information

Aftercare Recovery Plan

To be completed by clients requesting a STAND ALONE detox		
Area of Recovery	**What will I do NEXT to progress my recovery**	**Time Scale**
Substance Use		
Physical Health		
Mental Health		
Social Relationships		
Housing		
Employment		
Money and debts		
Offending		

I confirm that the information I have provided is accurate and that I would like to proceed with my application for detoxification at BAC O'Connor

Client Name	**Client Signature**	**Date**
Worker Name	**Worker Signature**	**Date**