Referral Form

Please ensure that all sections of this referral is completed in full. We will be unable to proceed further with this referral is information is incomplete and the form will be returned to the referrer for further information.

If you experience any issues completing this form, please contact our **Assessments Team on 01283 545 239**

126 Station Street
Burton-on-Trent
Staffordshire
DE14 1BX
01283 537 280
www.bacandoconnor.co.uk

Client Details			
Forenames		Surname	
Alias		Date of Birth	
Sex		Gender Identity	
Nationality		Ethnicity	

For the purpose of our referral process, BAC use ethnicity data as defined by NDTMS as follows

White British	White/Black African	White/Black Caribbean	White & Asian	Other Mixed	White Irish	African
Caribbean	Chinese	Other Black	Other White	Indian	Pakistani	Bangladeshi
Other Asian	Not Disclosed	Other				

First Language		Interpreter Needed	Yes ☐ No ☐
BSL Sign Language	Yes ☐ No ☐	Makaton Sign Language	Yes ☐ No ☐
Sexuality	Heterosexual ☐ Homosexual ☐ Bi-sexual ☐ Not Disclosed ☐		
Current Address			
Contact Address			
Contact No Landline		Contact No Mobile	

Is the Home Address	☐ permanent	☐ temporary	☐ NFA	☐ rough sleeping
Housing Status	☐ own home – owned	☐ own home – rented	☐ hostel	☐ supported housing
	☐ - living with family	☐ prison	☐ sofa surfing	☐ other

GP Name		Surgery Address	
Postcode		Telephone No	

Professionals Involvement – please provide details in full of all professionals who are currently providing support *(please add additional persons on the notes sheet if required)*

Name **(Referrer)**		Role	
Organisation		Contact No	
Full Address			
Name		Role	
Organisation		Contact No	
Full Address			
Name		Role	
Organisation		Contact No	
Full Address			
Name		Role	
Organisation		Contact No	
Full Address			

Prescribed Medication – *please provide information all medication prescribed (additional information can be added to the notes sheet)*				
Medication	**Amount**	**Dispensing Regime**	**Reason for Medication Prescribed**	**Date Prescribing Commenced**

Medical History – *please provide information regarding any diagnosed medical conditions currently, alongside any concerns that the client may have regarding their physical health*							
Description	**Significant Illness**		**Significant Injury**		**Current Treatment in Place**	**Accessing Primary Care**	
	Yes ☐	No ☐	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐		Yes ☐	No ☐

Psychiatric History – *please provide all information relating to the clients mental health, both those with a formal diagnosis, under investigation and a current concern with the client*					
Condition / Concern	**Formal Diagnosis**		**Date Diagnosed**	**Accessing Primary Care**	
	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐		Yes ☐	No ☐
	Yes ☐	No ☐		Yes ☐	No ☐
Additional Information					
Mental Capacity: *in line with the guidelines set in the Mental Capacity Act, does the client have*	☐ Full Capacity		☐ Fleeting Capacity		

BBV & Covid-19 Status							
Hepatitis B		**Hepatitis C**		**HIV**		**Covid-19**	
Infected	Yes ☐ No ☐	Tested	Yes ☐ No ☐	Tested	Yes ☐ No ☐	Vaccine 1	Yes ☐ No ☐
Vaccinated	Yes ☐ No ☐	Date		Date		Date Vaccinated	
Accessing Treatment	Yes ☐ No ☐	Result		Result		Vaccine 2	Yes ☐ No ☐
				Accessing Treatment	Yes ☐ No ☐	Date Vaccinated	
						Isolating	Yes ☐ No ☐
						Currently Positive	Yes ☐ No ☐
						Positive previous 28 days	Yes ☐ No ☐

Current Substance Use												
Primary Substance			**Secondary Substance**				**Other Substances**					
How is the Primary Substance Administered	**Oral**	Yes ☐ No ☐	**Inject**	Yes ☐ No ☐	**Sniff**	Yes ☐ No ☐	**Smoke**	Yes ☐ No ☐	**Other**	Yes ☐ No ☐		
Injecting Status	Never Injected	Yes ☐ No ☐	Currently Injecting	Yes ☐ No ☐	Previously Injected	Yes ☐ No ☐	Declined to Answer	Yes ☐ No ☐				
Please complete the attached Audit-C and SADQ forms		**AUDUT C Score**		**SADQ Score**		**Date Completed**						

Substance History – *please provide a detailed over-view of the client's substance use/misuse history Please include dates when use started, detoxification and rehabilitation history, number of years in treatment, periods of sobriety, currently awaiting a community/inpatient detox, engagement with treatment services*	
Past History (to include) • Substances used • Routes • Age of use started • Periods of sobriety • Engagement with services • overdose/hospital admissions	
Detoxification / Residential Rehab History • Previous detox, date & outcome • Previous residential rehab, date & outcome • Currently detox referrals	

Family & Parenting Information							
Parental Status							
Biological, Adoptive, Step Child	**Gender**	**Age**	**Living with Client**	**Social Care Involvement**	**Child Protection Plan in Place**	**Looked After Child**	**Current Contact with Child**
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							
Child 6							
Is the client pregnant		Yes ☐	No ☐	Is the client partner pregnant		Yes ☐	No ☐
Expected date of confinement				Social Care Involvement		Yes ☐	No ☐
If answered yes to Social Care, please provide details including lead Social Worker name and contact details							

Accommodation			
Current Accommodation			
Is the current accommodation secure and suitable for the clients needs		Yes ☐	No ☐
If no, provide details			
Does the client wish to return to their current accommodation once they have graduated from the BAC residential rehab programme		Yes ☐	No ☐
If no, provide details			

Forensic History			
Please provide a full and detailed history of offending behaviours below. If you require additional space please add to the additional information sheet			
Offence	Date	Sentencing	Current Conditions

Offence	Date	Sentencing	Current Conditions

Is the client currently on bail?	Yes ☐	No ☐

Offence	Date	Conditions	Court Date

Please discuss with your client the main reasons for their offending and current attitude, thoughts and feelings towards their offending behaviour (detail below)

Transport - *where possible BAC would prefer the client should be accompanied to minimise risk of 'last chance' substance misuse, and particularly post-detox accidental overdose*

Details of transport arrangements to and from BAC O'Connor

Clients View – *please note that the following section must be completed with the client at all times*		
Have you been provided with a copy of the BAC Residential Rehab Information Sheet	Yes ☐	No ☐
Do you fully understand all of the information provided in this document?	Yes ☐	No ☐

Can you explain us to why you wish to be consider for the opportunity to access the BAC Residential Rehabilitation Programme

What are the 3 main things that you want to achieve as part of the BAC Residential Rehabilitation Programme
What are your hopes from being part of the BAC Residential Rehabilitation Programme
What are your fears from being part of the BAC Residential Rehabilitation Programme
What are your plans once you have graduated from the BAC Residential Rehabilitation Programme

I can confirm that the information provided is accurate and up to date at the time of submission			
Referrer	Print Name	Signature	Date
Client	**Print Name**	Signature	Date
If no client signature please state reasons why and confirm that the client has given consent for the referral to be submitted			

Additional Documents – please tick to confirm that the following documents (where appropriate) have been provided as part of this referral					
Client Risk Assessment	Yes ☐	No ☐	Education, Health & Care Plan	Yes ☐	No ☐
GP Summary	Yes ☐	No ☐	OASys Risk & Needs Assessment	Yes ☐	No ☐
Mental Health Care Plan	Yes ☐	No ☐	AUDIT C	Yes ☐	No ☐
Child Protection Plan	Yes ☐	No ☐	SADQ	Yes ☐	No ☐
PHQ-9 Assessment	Yes ☐	No ☐	GAD-7 Assessment	Yes ☐	No ☐
Other supporting Information	Yes ☐	No ☐	Please state:		

Additional Information – please use this section to add information where the space provided on the form is not sufficient, any additional information you feel is relevant or additional views from your client