Bridge Substance Misuse Programme
63c Gold Street
Northampton NN1 1RA

Bridge

Referral Form

OFFICE USE ONLY

☐ Client dropped in and completed a self-referral form.
Date: ____________ Time: ________ Duration: ________ Personnel: ____________

☐ Referrer hand delivered a completed a referral form.
Date: ____________ Personnel: ____________

☐ Referral form received by post.
Date: ____________ Time: ________ Duration: ________ Personnel: ____________

☐ Referral form completed at induction.

REFERRER DETAILS

Form Completed By: Referrer: ☐ Bridge Staff: ☐ Self: ☐

Preferred Bridge Site: Northampton: ☐ Wellingborough: ☐ Corby: ☐

Referrer's name: ______________________

Referring agency: ______________________

Telephone: ______________________ Email: ______________________

TREATMENT

Is the client currently in treatment with S2S?	Yes: ☐	No: ☐
Has the client ever been in treatment with S2S?	Yes: ☐	No: ☐
Does the client consent to us sharing data with S2S?	Yes: ☐	No: ☐

Client signature for consent to share data with S2S: ______________________

PERSONAL DETAILS

First names: ______________________

Surname: ______________________

Address: ______________________

____

Accommodation Need:

Housing Problem: ☐

No Housing Problem: ☐

NFA – Urgent Housing Problem: ☐

Post Code: ____________ Country of Birth: ____________ Ethnicity: ____________

Email: ______________________ Telephone: ______________________

Date of birth: ____________ Gender at birth: Male: ☐ Female: ☐

Self-declared Gender: Female: ☐ Male: ☐ Non-Binary: ☐ Other: ☐ Not Stated: ☐

SUBSTANCE USE

Substance use – History: Drugs: ☐ (Please specify below) Alcohol: ☐

Substance use – Current: Drugs: ☐ (Please specify below) Alcohol: ☐

PRIMARY (MAIN) SUBSTANCE (one only)

Substance: ____________________

Age first used: ____________________

SUBSTANCE ROUTE:

Inject: ☐ Sniff: ☐

Oral: ☐ Smoke: ☐

Other: ☐

SECOND SUBSTANCE (one only)

Substance: ____________________

Age first used: ____________________

SUBSTANCE ROUTE:

Inject: ☐ Sniff: ☐

Oral: ☐ Smoke: ☐

Other: ☐

THIRD SUBSTANCE (one only)

Substance: ____________________

Age first used: ____________________

SUBSTANCE ROUTE:

Inject: ☐ Sniff: ☐

Oral: ☐ Smoke: ☐

Other: ☐

OTHER SUBSTANCES (any number)

Substance: ____________________

____

____

INJECTION STATUS

Never injected: ☐

Previously injected (but not currently): ☐

Currently injecting: ☐

Declined to answer: ☐

HEALTH

MISCELLANEOUS

Smoking Status:

Currently smoking: ☐ Previously smoked: ☐ Never smoked: ☐

Weight problem?

No weight problem: ☐ Overweight: ☐ Underweight: ☐

HEALTH (Cont)

MISCELLANEOUS (Cont)

Have you been referred for alcohol related disease in the last 4 weeks? Yes: ☐ No: ☐

Have you been referred for Hepatitis C treatment? Yes: ☐ No: ☐

Have you ever been administered naloxone? Yes: ☐ No: ☐

MENTAL HEALTH

Mental health treatment need identified:

Yes: ☐ No: ☐

Mental health diagnosis:

Yes: ☐ No: ☐

If yes, please give diagnosis:

What treatment is being received?

Engaged with a community mental health team: ☐

Engaged with IAPT (e.g. Wellbeing Team): ☐

Has space in place of safety for MH crises: ☐

Psychosocial or pharmacological treatment: ☐

Receiving MH treatment from GP: ☐

Need identified but NO treatment being received: ☐

GP's name: ____________________

Surgery name: ____________________

Surgery address: ____________________

____________________ Telephone: ____________________

CHILDREN

Is the client a parent to a child under 18? Yes: ☐ No: ☐ **Number of under 18s living with client:** ____

Do you have parental responsibility for the above children? Yes: ☐ No: ☐

If yes, then please pick an option:

All of the children live with the member: ☐

Some of the children live with the member: ☐

None of the children live with the member: ☐

Is the member pregnant? Yes: ☐ No: ☐

If yes, due date: ____________________

Undisclosed number: ☐ Client declined to answer: ☐

Please select Early Help option: Child in need: ☐

Early help: ☐

Child protection plan: ☐

Looked after child: ☐

None: ☐

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EX FORCES

Have you served in the Armed Forces?

Yes: ☐ No: ☐

Are you?

Serving: ☐ Veteran: ☐ Reservist: ☐

Which Force(s) have you served in?

Airforce: ☐ Marines: ☐

Army: ☐ Navy: ☐

CRIMINAL OFFENCES

Current offences (the sentence is still in effect) OR current crime involvement: (If none, please write none)	Offending history (the sentence is over): (If none, please write none)

Probation officer: ______________________________

EMPLOYMENT

Employment status:

Long term sick or disabled: ☐ Homemaker: ☐
Unemployed and seeking work: ☐ Not known: ☐
Unemployed and not seeking work: ☐ Not stated: ☐
Retired from paid work: ☐ Pupil/Student: ☐
Unpaid voluntary work: ☐ Other: ☐
Regular employment: ☐ Not receiving benefits: ☐

Sex Working:

Not a sex worker: ☐ Selling sex from premises: ☐
Selling sex from street: ☐

Time since last paid employment:

Less than 1 year: ☐
1 – 2 years: ☐
2 – 3 years: ☐
More than 3 years*: ☐
Never employed: ☐
Currently employed: ☐
Client declined to answer: ☐

***If more than 3 years, please state:** ____

DISABILITIES

None: ☐
Behaviour & emotional: ☐
Hearing: ☐
Learning disability: ☐
Manual dexterity: ☐
Mobility & gross motor: ☐
Perception of physical danger: ☐
Personal, self-care & continence: ☐
Progressive conditions & physical health: ☐

Sight: ☐
Speech: ☐
Other: ☐

If other, please state:

Referrer's signature: ______________________ Referral Date: ______________________