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

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: _____

_____

Post Code: _____

Email: _____ Telephone: _____

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

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

Accommodation Need:

Housing Problem: ☐

No Housing Problem: ☐

NFA – Urgent Housing Problem: ☐

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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: ☐

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HEALTH (Cont)

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: ☐

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: ☐

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EMPLOYMENT

Employment status:

Long term sick or disabled:	☐	Homemaker:	☐	Less than 1 year:	☐
Unemployed and seeking work:	☐	Not known:	☐	1 – 2 years:	☐
Unemployed and not seeking work:	☐	Not stated:	☐	2 – 3 years:	☐
Retired from paid work:	☐	Pupil/Student:	☐	More than 3 years*:	☐
Unpaid voluntary work:	☐	Other:	☐	Never employed:	☐
Regular employment:	☐	Not receiving benefits:	☐	Currently employed:	☐
				Client declined to answer:	☐

Sex Working:

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

Selling sex from street: ☐

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

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: _____

DISABILITIES

None:	☐	Sight:	☐
Behaviour & emotional:	☐	Speech:	☐
Hearing:	☐	Other:	☐
Learning disability:	☐	If other, please state:	
Manual dexterity:	☐		
Mobility & gross motor:	☐		
Perception of physical danger:	☐		
Personal, self-care & continence:	☐		
Progressive conditions & physical health:	☐		

Referrer's signature: _____ Referral Date: _____