



Referral Form

REFERRER DETAILS

I am referring myself (Please leave the rest of this box blank)

I am referring someone else (Please complete the rest of this box)

Referring agency: _____

Referrer's name: _____

Telephone: _____ Email: _____

PERSONAL DETAILS

First names: _____

Surname _____

Address: _____

Post Code: _____

Email: _____ Telephone: _____

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

DOCTOR

GP's name: _____

Surgery name: _____

Surgery address: _____

Telephone: _____

CHILDREN

Is the client a parent? Yes: No:

Number of children living with client: _____

If yes, then please pick an option:

Undisclosed number: Client declined to answer:

All of the children live with the member:

Please select Early Help option: Child in need:

Some of the children live with the member:

Early help:

None of the children live with the member:

Child protection plan:

Is the member pregnant? Yes: No:

Looked after child:

If yes, due date: _____

None:

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: _____

SUBSTANCE USE

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

Alcohol:

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

Alcohol:

PRIMARY (MAIN) SUBSTANCE (one only)

SUBSTANCE ROUTE

Substance: _____

Age first used: _____

Inject:

Oral:

Sniff:

Smoke:

Other:

SECOND SUBSTANCE (one only)

SUBSTANCE ROUTE

Substance: _____

Age first used: _____

Inject:

Oral:

Sniff:

Smoke:

Other:

THIRD SUBSTANCE (one only)

SUBSTANCE ROUTE

Substance: _____

Age first used: _____

Inject:

Oral:

Sniff:

Smoke:

Other:

SUBSTANCE USE (Cont)

OTHER SUBSTANCES (any number)

Substance: _____

INJECTION STATUS

Never injected:

Previously injected (but not currently):

Currently injecting:

Declined to answer:

EMPLOYMENT

Employment status:

Homemaker:

Long term sick or disabled:

Not known:

Not receiving benefits:

Not stated:

Other:

Pupil/Student:

Regular employment:

Retired from paid work:

Unemployed and seeking work:

Unpaid voluntary work:

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: _____

Sex Working:

Not a sex worker:

Selling sex from premises:

Selling sex from street:

ACCOMMODATION

Accommodation need:

Housing problem:

NFA – Urgent housing problem:

No housing problem:

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:

MENTAL HEALTH

Mental health treatment need identified:

Yes:

No:

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:

Mental health diagnosis:

Has the client been diagnosed?

Yes:

No:

If yes please give diagnosis:

MISCELLANEOUS

Smoking status:

Currently smoking:

Previously smoked:

Never smoked:

Weight problem?

No weight problem:

Overweight:

Underweight:

Ex forces?

No:

Airforce:

Army:

Marines:

Navy:

TREATMENT

Is the client now, or has ever been, in treatment (i.e. 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: _____

Referrer's signature: _____

Referral date: _____

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: _____ Time: _____ Duration: _____ Personnel: _____

Referral form received by post.

Date: _____ Time: _____ Duration: _____ Personnel: _____

Referral form completed at induction.