REACH OUT RECOVERY

CRi

## Referral Form

We are really pleased that you have made the decision to contact ROR and hope that we can support you in identifying and working towards your goals and aspirations. In order for us to best support you, we need to understand your current situation so please answer the following questions. If you feel unable to complete any of this form please leave it blank and we can discuss it together at your first appointment.

<table>
<tr><td colspan="4">What would you like to achieve by working with us?</td></tr>
<tr><td colspan="4">How did you hear about our service?</td></tr>
<tr><td colspan="2">First name:</td><td colspan="2">Surname:</td></tr>
<tr><td>☐ Mr ☐ Mrs<br>☐ Miss ☐ Ms<br>☐ other _____</td><td>Gender: ☐ Male ☐ Female</td><td>DOB:</td><td>Age:</td></tr>
<tr><td colspan="3">Address and Postcode:</td><td>Telephone Number:</td></tr>
<tr><td>Nationality:</td><td>Ethnic Origin:</td><td colspan="2">First Language:</td></tr>
<tr><td>Accommodation Need:<br>☐ Problem with Housing<br>☐ No housing problem<br>☐ Homeless</td><td colspan="3">Relationship:<br>☐ Single ☐ With a partner ☐ Married ☐ Civil Partnership<br>☐ Divorced ☐ Widowed ☐ Separated</td></tr>
<tr><td>Sexuality:<br>☐ Heterosexual<br>☐ Homosexual<br>☐ Bisexual</td><td>Have you previously received treatment for substance misuse:<br>☐ Yes ☐ No</td><td colspan="2">Are you currently receiving treatment from mental health services: ☐ Yes ☐ No<br>If so who are you receiving support from:</td></tr>
<tr><td colspan="4">Are you currently taking any prescribed medications? ☐ Yes ☐ No<br>If so please list them below:</td></tr>
<tr><td colspan="2">Employment Status:<br>☐ Regular employment<br>☐ Unpaid work (voluntary)<br>☐ Student<br>☐ Unemployed – seeking work<br>☐ Long term illness</td><td colspan="2"><br>☐ Unemployed – receiving no benefits<br>☐ Homemaker<br>☐ Retired<br>☐ Other<br>☐ Receiving benefits –which one?_____</td></tr>
<tr><td colspan="2">GP name and surgery:<br><br>Does your GP know about your alcohol and/or drug use:<br>☐ Yes ☐ No</td><td colspan="2">Next of Kin: (we will only contact his person in a case of an emergency)<br><br>Do you consent to us sharing information with this person:<br>☐ Yes ☐ No</td></tr>
</table>

## Drug Use

| | |
|---|---|
| Primary Problem Substance:<br><br>Age First Used:<br><br>How do you use:<br>☐ Inject ☐ Sniff ☐ Smoke ☐ Oral<br>☐ Other: | How often do you use?<br><br>How much do you use?<br><br>How much do you spend a week on this substance? |
| Secondary Problem Substance:<br><br>Age First Used:<br><br>How do you use:<br>☐ Inject ☐ Sniff ☐ Smoke ☐ Oral<br>☐ Other: | How often do you use?<br><br>How much do you use?<br><br>How much do you spend a week on this substance? |
| Third Problem Substance:<br><br>Age First Used:<br><br>How do you use:<br><br>☐ Inject ☐ Sniff ☐ Smoke ☐ Oral<br>☐ Other: | How often do you use?<br><br>How much do you use?<br><br>How much do you spend a week on this substance? |
| Have you ever injected drugs:<br>☐ Never injected<br>☐ Previously injected<br>☐ Currently inject | If you have previously injected drugs:<br>At what age did you first inject?<br>Have you injected in the last 28days? ☐ Yes ☐ No<br>Have you ever shared injecting equipment? ☐ Yes ☐ No<br>Have you shared injecting equipment in the last 28 days?<br>☐ Yes ☐ No |
| Have you ever been tested for Hepatitis B?<br>☐ Yes ☐ No ☐ Unsure<br><br>Have you ever had a vaccination for Hepatitis B?<br>☐ Yes ☐ No ☐ Unsure | Have you ever been tested for Hepatitis C?<br>☐ Yes ☐ No ☐ Unsure<br><br>If yes what date were you tested: |
| Other comments | |

## Alcohol Use

Client's Name:

Professional's Name: | Date:

Please answer the following questions about alcohol and then score your responses:

Thinking about your drinking behaviour over the past 12 months answer the following questions and circle the answer that applies to you. Place the score for each answer (0-4) in the circle on the right.

| FRAMES TOOLKIT – AUDIT | 0 | 1 | 2 | 3 | 4 | My Score |
|---|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Once a month or less | 2-4 times per month | 2-3 times per week | 4 + times per week | |
| 2. How many standard alcoholic drinks (pints/ shots/ alcopops/ glasses of wine) do you have on a normal day when you drink? | 1-2 | 3-4 | 5-6 | 7, 8, 9 | 10+ | |
| 3. How often do you have six or more drinks in one session? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 4. How often in the past year have you not been able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 5. How often in the last year have you failed to do what was expected of you because of drinking, for example, missed an appointment? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 6. How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 7. How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 8. How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily (or almost daily) | |
| 9. Have you or someone else been injured as a result of your drinking? | No | | Yes, but not in the past year | | Yes, during the past year | |
| 10. Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down? | No | | Yes, but not in the past year | | Yes, during the past year | |
| | | | | | **My Audit Score: (total questions 1-10)** | |

The total score from these questions helps us to determine your current drinking levels; this will be discussed further with you at your first appointment.