

Drug and Alcohol Referral Form (UKR)

Please complete all sections

Full Name:	DOB:	Contact Number:
Current Address & Room Number:		
Date of Referral:		
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Identifies As _____		

Interpreter Needed: Yes No , Ukrainian Russian , I understand that by ticking box below on this form, I give consent to recording of my personal information which is confidential to services involved. Consent does allow that information to be discussed as a team and records are also retained in electronic version (computer). Yes No

Referring Agency - please select:

Psychologist Community Worker G.P. Accommodation Centre Staff Self Other

If Other, Please Specify:

Referrer Details:

Name:

Occupation:

Phone No.:

Email:

Reason for Referral:

Drug/Alcohol Use History:

Behavioural Issues:

Is the Client on Methadone/ Suboxone? Yes No How many mls: _____ Detox/Maintenance (Please Circle)

Prescribing Services:

Contact Details:

Is the Client on any prescribed Medication? Yes No

If yes, state name of medication(s):

Prescribing Services:

Contact Details:

Other Professionals Involved (Probation/Social Care/Child and Family etc.)	Contact Details

Any other relevant information: