**ALCOHOL AND DRUGS SUPPORT SWS**

**INITIAL REFERRAL FORM**

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| --- | --- | --- | --- |
| **Name** |  | **Date of Birth:** |  |
| **Known as:** |  | **Gender:** |  |
| **Address:** |  | **Landline:** |  |
|  | **Mobile No:** |  |
| **Postcode** |  | **Email:** |  |
| **Consent Gained****(GamCare Only)** |  | **Ethnicity** |  |

Referral Type: Choose an item.

Service User Aware of Referral: Choose an item.

Best method of first contact: Choose an item.

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| --- |
| **Presenting Circumstances:** *(e.g. current usage, reason for referral)* |
| **Any Associated Risks:** (*e.g. risk to self/others including staff, mental/physical health problems, court involvement)* |
| **Other Agency Involvement:**NHS SDAS [ ] We Are With You [ ] Social Work [ ] Criminal Justice Social Work [ ] Other [ ]  *(Please give details below)* |
| **Other Relevant Information:** |

|  |  |
| --- | --- |
| Referrer Name & Agency: |  |
| Contact No / Email: |  |

|  |  |
| --- | --- |
| GP Details: |  |

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| --- | --- |
| Referral Date: |  |