**ALCOHOL AND DRUGS SUPPORT SWS**

**INITIAL REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **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.

|  |
| --- |
| **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: |  |

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