In partnership with:

i-access Drug & Alcohol Services

catalyst HELPING PEOPLE CHANGE

SABP i-access Drug & Alcohol Services Referral Form for Surrey Residents

Referrer Details

Referral Source	☐GP / ☐Social Services / ☐CMHRS / ☐Self / Other: ☐Probation NOMS/KCRA* (*delete as appropriate)		
Name of Referrer		**Job Title of Referrer**	
Contact Details of Referrer	Phone Email	**Client aware of referral?** ☐**Yes /** ☐**No**	

Client Details

First Name	**Surname**		
Date of Birth	**Title**	**Gender**	☐**Male** ☐**Female**
Contact Numbers: **Mobile**	**Landline**		
Address **Post Code**	**GP Name** **GP Surgery**		
Interpreter Required? **(please specify language)**	☐**Yes /** ☐**No**	**NHS Number**	

Contact Consent – Please tick ALL that apply

Landline	☐Yes / ☐No	→ **Voicemail**	☐Yes / ☐No	**Letter**	☐Yes / ☐No
Mobile	☐Yes / ☐No	→ **Voicemail**	☐Yes / ☐No	**Text Message**	☐Yes / ☐No

Outline of current substance misuse problem

Clinician to ascertain quantities / units of drugs or alcohol currently being used

What is your goal?

☐ **ABSTINENCE**	☐ **NON-ABSTINENCE**

History of substance misuse and previous treatment

Have you previously received drug or alcohol treatment?	☐Yes / ☐No	If yes, please give approximate date:

Please provide brief details of any other medical or mental health problems?

Include any physical health conditions and if mental health problems ascertain CMHRS involvement

Please contact your local Community Mental Health Recovery Service (CMHRS) should you require any support with mental health:

Elmbridge: 020 8783 3950
Epsom: 01372 204000
Guildford: 01483 443551
Mole Valley: 01306 502400
Reigate: 01737 272301
Runnymede: 01932 723392
Spelthorne: 01932 794848
Surrey Heath: 01276 605522
Tandridge: 01883 385481
Waverley: 01483 528100
Woking: 01483 756318

If you require urgent out of hours support please contact the Crisis Helpline on 0300 456 83 42

GP and Hospital Referrals – please attach a copy of the client's medical history, recent prescriptions and recent blood test results to this referral

Is the client pregnant? ☐ Yes / ☐ No

Any other important factors i.e. – Safeguarding Adult / Children concerns Convictions / Probation / History of violence – please provide details.

Please inform us of any risks we should be aware of.

☐ **Yes** ☐ **No**	**I have discussed this referral with the client and they consent to this information being shared with the Surrey and Borders Partnership NHS Foundation Trust i-access Community Drug & Alcohol Teams**

***If this box is not marked "Yes" the referral process may be delayed as we may need to write to the client to ask if they would like an appointment with us**

MANDATORY INFORMATION

We will be unable to process this referral until this information is provided

If alcohol is presenting problem please complete this AUDIT C Questionnaire

Questions	0	1	2	3	4	Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Please ensure you have given the referee's NHS Number and send this referral either:

- By **Email**: from a **secure** account to: rxx.iaccess@nhs.net or from a **non-secure** account as a password protected document.
- By **Post**: **i-access Admin Hub, Laurel House, Farnham Road Hospital, Guildford GU2 7LX**
- By Safe Haven **Fax**: **01483 302617**
- If you have any queries please call: **0300 222 5932**

i-access Use Only		
Referral taken / received by: (print full name)		**Date:**
Audit score less than 10 with no complex needs, send information pack		
Previous client? Y/N	**Halo ID:**	**Year(s) of discharge:**
Previous Engagement with:		
Any other information:		