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**Referral Form (Confidential)**

**CHART Kirklees; we are an open access, confidential service which supports all individuals 18 years of age and over which supports individuals affected by Alcohol & Substance use in Kirklees. (Please can the form be completed in full)**

***\*Please note that for any clients wanting home visits we do not accept self-referrals, discuss with your GP and ask them to complete referral on your behalf if you meet the necessary criteria.***

**Referrer’s Details Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has this client attended CHART Kirklees services before? Yes No**

**Client Details:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address (c/o): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_\_\_**

**Home Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**GP Contact Details:**

**Registered With GP Yes No**



**GP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Please tick box if GP Surgery uses EMIS SystmOne**

**Identification of Alcohol/Drug Use:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Alcohol/Drug Used** | **Daily Amount (Units/Grams)** | **\*Frequency** | **\*Route (Oral, injecting, Smoking, Sniffing/Snorting)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Frequency:**

**(Please circle as appropriate)**

* **Daily**
* **More than once daily**
* **Weekly**
* **Monthly**

**Main Reason for Referral:**

**(Please provide in depth details as why you want to refer; is it for outreach visits and explain why you are requesting these.)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are there any other services involved Yes No**





**Has Shared Care Service been explored Yes No**



**If yes to either question above, please give details** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child Care Responsibilities Yes No**



**If Yes to above question; Age/Ages of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Related Issues/Concerns Risks (Please circle if applicable)**

* **Mental Health**
* **Homelessness**
* **Pregnant**
* **Safeguarding (Child/Adult)**
* **Self-Harm**
* **Harm to others**
* **Physical Illness e.g. housebound, mobility issues (to what extent)**
* **Agoraphobic**
* **Anxiety issues (to what extent)**
* **Other (Please state)**

**If any risk circled please supply further information:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Client Consent**

|  |  |  |
| --- | --- | --- |
| **PLEASE COMPLETE ALL SECTIONS** | **Yes** | **No** |
| **I consent for this referral being completed** |  |  |
| **I can be contacted via letter at home** |  |  |
| **I can be contacted via telephone or mobile** |  |  |
| **I can be contacted via the agency referring** |  |  |
| **I can be contacted through home visit** |  |  |
| **I consent to being registered on System One****(Referrer to advise, SystmOne used by most Health Care Organisations such as GP, Hospital etc)****Please leave blank if you are not confident on SystmOne confidently procedure.**  |  |  |

**Client Signature:**

**Please Note: Ensure all boxes are ticked appropriately and must be signed by the client by hand otherwise we will not be able to accept the referral.**

**Clients will be contacted in 5 working days on receipt of the referral being received**

**If the client consents the referring agency will be contacted within 5 working days of the referral outcome.**

**Once completed this will need to be either posted or faxed back to: 01924 485761**

**Please post to (for both Dewsbury and Huddersfield referrals):**

**FAO: CHART Kirklees - CGL**

**(Choices for Health In Addiction Recovery and Treatment)**

**Change Grow Live**

**3 Wellington Street, Dewsbury**

**WF13 1LY**

**For electronic copy please email:** referrals.chart@cgl.org.uk