**Community Links Dual Diagnosis Referral Form**

This service provides an early intervention floating support service for individuals aged 16 and over with moderate to severe mental health and co-existing substance misuse problems (dual diagnosis) to live more independently in the community.

**N.B: When completing this form please ensure that all sections are completed and attach a recent risk assessment in ALL cases. Incomplete referrals may result in a delay in processing.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date referral received** |  | | | | | **Referral no.** | | | |  |
| **Personal Details** | | | | | | | | | | |
| Name: | |  | | | | | Date of Birth: | |  | |
| Previous Names: | |  | | | NI No: | | | | | |
| Address: | | | | | | | | | | |
| Postcode: | |  | Contact telephone | | | | | Home No:  Mobile No: | | |
| Name and Relationship of Next of Kin: | | | | | | Contact No:  Can they be contacted (Y/N): | | | | |
| Residential Status:  Owner occupier  Private rented  Living with friends/family  Council Tenant  Hostel | | | | | | Homeless  Housing Association  Hospital  Secure Accommodation  Other (Please State)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Risks** | | | |  | | | | | |  |
| Does the client have any of the following issues | | | | Yes/No | | | | | | Details |
| Housing (Is homeless or at risk of becoming homeless) | | | |  | | | | | |  |
| Drugs/alcohol issues | | | |  | | | | | |  |
| Mental/Physical health issues (diagnosed or undiagnosed) | | | |  | | | | | |  |
| Child protection issues (does the client have any children who are at risk) | | | |  | | | | | |  |
| **Risk Assessment** | | | | | | | | | | |
| Does the client have an up to date Risk Assessment? | | | | | | Yes | | | | No |
| Is a copy being sent with this referral? | | | | | | Yes | | | | No |
| **Referrers Details** | |  | | | | | | | | |
| Name: | |  | | | | | | | | |
| Role and Agency: | |  | | | | | | | | |
| Address: | |  | | | | | | | | |
| Contact Number: | |  | | | | | | | | |
| Email Address: | |  | | | | | | | | |
| **Any other professionals involved** | | | | | | **Contact Number** | | | | |
| GP: | | | | | |  | | | | |
| Probation: | | | | | |  | | | | |
| Care Coordinator /CPN: | | | | | |  | | | | |
| Other: | | | | | |  | | | | |

**Community Links Dual Diagnosis Client Consent Form**

|  |  |  |
| --- | --- | --- |
| **If the client consents the referral agency will be contacted with referral outcome** | **Yes** | **No** |
| I consent for this referral to be completed |  |  |
| I can be contacted via a letter to my home |  |  |
| I can be contacted via landline or mobile |  |  |
| I can be contacted via the referring agency |  |  |
| I can be contacted via a home visit |  |  |
| I consent to being registered on CMS *(this is a case management system that Community Links use purely for recording purposes)* |  |  |
| **Signed by the client:**  **Please Note: Ensure all boxes are ticked appropriately and must be signed by the client by hand (if possible) Verbal consent is required in cases where a signature is not possible.**  **Clients will be contacted on receipt of the referral** | | |
| **Diversity and Inclusion** | | |
| Is English the clients first language? | **Yes** | **No** |
| If English is not their first language, what is? |  | |
| Will the client require an interpreter? |  |  |
| Are there any communication issues? |  |  |
| Does the client have a learning disability |  |  |
| Is the client autistic? |  |  |
| Does the client have memory problems? |  |  |
| Does the client have any specific contact requirements |  |  |

|  |  |  |
| --- | --- | --- |
| **Ethnicity** |  | **Disability** |
| A – White - Any other white background | Yes |
| A – White – British | No |
| A – White - Irish | Client does not wish to state |
| B – Mixed – Any other mixed background | Client not asked to state |
| B – Mixed – White and Asian |  |
| B – Mixed - White and Black African |
| B – Mixed – White and Black Caribbean |
| C – Asian or British Asian – Any other Asian background | **Gender** |
| C – Asian or British Asian – Bangladeshi | Female |
| C – Asian or British Asian – Indian | Male |
| C – Asian or British Asian – Kashmiri | Gender assigned at birth? |
| C – Asian or British Asian – Pakistani | **YES NO** |
| D – Black or Black British – African |
| D – Black or Black British – Any other Black background | **Sexuality** |
| D – Black or Black British - Caribbean | Heterosexual (straight) |
| E – Other Ethnic Groups – Any other Ethnic background | Gay |
| E – Other Ethnic Groups – Chinese | Lesbian |
| Client does not wish to state | Bisexual |
| Client not asked to state | Self-defined |
|  | Client does not wish to state |
| Client not asked to state |
|  |
| **Religion** | **Relationship Status** |
| Christian – All denominations | Single |
| Buddhist | Co-habiting |
| Hindu | Married |
| Jewish | Civil Partnership |
| Muslim | Other |
| Sikh | Client does not wish to state |
| No belief | Client not asked to state |
| No religion |  |
| Other – please state | **Residency** |
| Client does not wish to state | Is the client a British citizen? |
| Client not asked to state | **YES NO** |
| Other – please state |

**Please return the completed referral form and any relevant documentation as soon as possible to enable us to process the referral quickly and efficiently.**

We aim to acknowledge receipt of referrals within 7 working days.

Please note: We prefer referrals to be emailed to us for processing, please ensure you save the referral form in a Password Protected document before sending to[**DualDiagnosis@commlinks.co.uk**](mailto:DualDiagnosis@commlinks.co.uk)If you prefer you can fax this referral form to us on **01924 422012**

Or via post to:

**Community Links Dual Diagnosis Service, Annexe 1, Unit 38, Batley Business Park, Technology Drive, Batley WF17 6ER**

Any queries, please call us on **01924 448975 Thank you**