



Date of Referral

ID Number

Nebula no.

Contact by letter ☐ Telephone ☐

CHI No.

Name of service user.....

Male ☐

Address.....

Female ☐

.....

D.O.B

Post Code.....

Ethnicity

Permanent or temporary address?

Telephone Landline..... Mobile.....

E mail address

Name of Referrer.....

Agency.....Telephone number.....

GP (Name, practice and number).....

Other contact/next of kin name & telephone number

CHI number

Has person given consent for referral? Yes / No

Has person used service before? Yes/No Details (eg previous worker).....

What is person's main substance used?

Amount and frequency

Length of use

What is person's other substances used?

Amount and frequency

Length of use

Injecting yes no

Prescribed medication

What does the person want from the service?

**Does the person have or is person in regular contact with children?
Are there any child protection concerns? (Enter ages and names of children)**

Can we contact A4C to discuss referral?

Is person in contact with other agencies? (Which ones+ level of contact)

Physical and mental health (any medical risk i.e. seizure activity, self harm)

**Is there anything we should know about risk? Is there existing risk assessment?
(forward) Criminal convictions/statutory orders (agency referral)**

Any other relevant information

Access needs/disability/literacy

Form completed by.....

Date.....

To make referral, phone BAS 01896 664 436 or Addaction 01896 757 843