Cranstoun Alcohol and Drug Recovery Service

(Adult Substance Misuse)

Referral Form

Cranstoun is a national charity empowering people to live healthy, safe and happy lives. We provide community-based alcohol, drug and support services. This form is to be **completed** when you or someone you know (18 years and over), requires support from Cranstoun.

**Referrals from other organisations**

Cranstoun will require a copy of the:

* Risk assessment and care plan (dated within the last 3 months)
* Care plan (dated within the last 3 months)
* Consent to share information document

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of referral:** |  | ***Office use only***  **Referral taken by**  **Duty worker name:** |  |
| **Source of referral:** | □ Self □ Organisation □ Doctor □ Other please specify: | | |
| **Referrer name:**  **Address:**  **Postcode:** | | **Referrer Email address:** | |
| **Referrer Contact number/s:** | |
| In line with the GDPR 2018 please confirm that you have discussed the referral with your client and they have agreed to it being made? □ Yes □ No  **If not, consent needs to be given for referral to be processed.** | | | |

Details about the person seeking a service from Cranstoun

|  |  |
| --- | --- |
| **Mr/Mrs/Ms/other:** | **Date of birth:** |
| **First name:** |
| **Surname:** | **Agreed contact methods:**  □ Mobile □ Phone □ Text  □ Letter □ Email  □ Leave message on phone |
| **Address:**  **Postcode:**  **Is this stable accommodation?** | **Email address:** |
| **Contact number/s:** |
| **Any special requirements for accessing Cranstoun:**  *Including mobility issues, interpreter required, days/times unable to attend appointments* | |
| **Reason for referral, why have you presented today?** | |
| **Are you registered with a GP?**  □ Yes □ No  **If so can we contact your GP so we can support you?**  □ Yes □ No | **GP Name and address:** |
| **Are you receiving support from any other agencies?** | |

Current substance use

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please specify:** | **Name of alcohol/drug**  *e.g. wine*  *e.g. heroin* | **Amount**  *e.g. 1 x 70cl bottle*  *e.g. 2 x £10 bags* | **Frequency**  *e.g. Daily (every evening)* | **How taken/used**  *e.g. Oral, Smoke*  *Sniff/snort, Inject* |
| **Current alcohol use** |  |  |  |  |
| Office use only  Alcohol Audit Score: |
| **Current substance use** |  |  |  |  |
| **Current medications** |  | | | |
| **Physical/mental health issues or concerns?** | If yes please provide details: | | | |
| **Have you had an overdose in the last month?**  □ Yes □ No | If yes please provide details: | | | |
| **Pregnant?**  □ Yes □ No | If yes please provide details: | | | |
| **Discharge from A&E in last month?**  □ Yes □ No | If yes please provide details: | | | |

|  |  |  |
| --- | --- | --- |
| Risks which may include housing related issues, injecting behaviour issues, criminal justice involvement issues, sex working, domestic abuse issues, children services involvement, adult safeguarding | | |
| **Risk to self:**   1. □ Yes □ No   e.g. injecting behaviour   1. sex working, suicidal ideation | If yes please provide details: | |
| **Risk to others:**   1. □ Yes □ No 2. e.g. criminal justice involvement, domestic abuse, children | If yes please provide details: | |
| **Risk from others:**  □ Yes □ No  e.g. domestic abuse, sex working | If yes please provide details: | |
| Please send completed referrals form by fax/email to:  Cranstoun  Castle House  14 Castle Street  Worcester WR1 3AD   |  |  | | --- | --- | | Office use only  Referrals & allocations | Priority referral?  □ Yes □ No | | | If you have any questions, please contact us on:  T 0300 303 8200  E  [cranstounworcsreferrals@cranstoun.org.uk](mailto:cranstounworcsreferrals@cranstoun.org.uk)  Secure email for partners:  [cranstounworcsreferrals@cranstoun.org.uk.cjsm.net](mailto:cranstounworcsreferrals@cranstoun.org.uk.cjsm.net) |

**Cranstoun Alcohol Screening and Assessment Tool**

 **NAME ………..………………………..…………………. DOB………..………………. ID No….………… Date………..……**

**One Standard Drink = One Unit**



**The following quantities of alcohol contain more than 1 unit**

**Alcohol Users Disorders Identification Test (AUDIT)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your**  **score** |
|  | **0 1 2 3 4** | | | | | **Total** |
| How often do you have a  drink that contains alcohol? | Never | Monthly  or less | 2-4 times  per month | 2-3 times  per week | 4+ times  per week |  |
| How many units do you have on a typical day  when you are drinking? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| How often do you have 6 units (female),  8 units (male), or more on one occasion? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| How often in the last year have you  found you were not able to stop  drinking once you had started? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| How often in the last year have  you failed to do what was normally expected  of you because of your drinking? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| How often in the last year have you  needed an alcoholic drink in the  morning to get you going? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| How often in the last year have you  had a feeling of guilt or regret after  drinking? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| How often in the last year have you  been unable to remember what  happened the night before because you  had been drinking? | Never | Less  than  monthly | Monthly | Weekly | Daily or  almost  daily |  |
| Have you or someone else been  injured as a result of your drinking? | No |  | Yes, but  not in the  last year |  | Yes,  during the  last year |  |
| Has a relative/friend/doctor/health  worker been concerned about your  drinking or suggested you cut down? | No |  | Yes, but  not in the  last year |  | Yes,  during the  last year |  |
|  | | | | **Grand total** | |  |

Scoring: 0-7 = Sensible / lower risk drinking; 8-15 = hazardous / increasing risk drinking; 16-19 = harmful / higher risk drinking and 20+ = possible dependence *NB: If Scored 8+ please include in risk management and/or care plan*

How much is too much? **Volume ml x ABV% ÷ 1000 = units**