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 onlyAlcohol 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 behaviour1. 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 □ Noe.g. domestic abuse, sex working | If yes please provide details: |
| Please send completed referrals form by fax/email to:CranstounCastle House14 Castle StreetWorcester WR1 3AD

|  |  |
| --- | --- |
| Office use onlyReferrals & allocations | Priority referral?□ Yes □ No  |

 | If you have any questions, please contact us on: T 0300 303 8200 E  cranstounworcsreferrals@cranstoun.org.ukSecure email for partners: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 adrink that contains alcohol? | Never | Monthly or less | 2-4 timesper month | 2-3 timesper week | 4+ timesper 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 | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| How often in the last year have youfound you were not able to stopdrinking once you had started? | Never | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| How often in the last year have you failed to do what was normally expected of you because of your drinking? | Never | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| How often in the last year have youneeded an alcoholic drink in themorning to get you going? | Never | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| How often in the last year have youhad a feeling of guilt or regret afterdrinking? | Never | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| How often in the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Lessthanmonthly | Monthly | Weekly | Daily oralmostdaily |  |
| Have you or someone else been injured as a result of your drinking? | No |  | Yes, but not in thelast year |  | Yes, during thelast year |  |
| Has a relative/friend/doctor/healthworker been concerned about yourdrinking or suggested you cut down? | No |  | Yes, but not in thelast year |  | Yes, during thelast 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**