**REFERRAL FORM**

For Drug & Alcohol Services within South Gloucestershire

PLEASE USE <https://www.gov.uk/find-local-council> TO ENSURE LOCAL AUTHORITY AREA FOR CLIENT IS SOUTH GLOS. BEFORE REFERRING.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Name**  **& Occupation:** | | | | | **Referral Date:** | | |
| **Please provide a brief description of why you are currently involved with this client***: (if ATR or DRR please note offence which led to this)* | | | | | | | |
| **Referrer Address:** | | | | | | | |
| **Referrer Email:** | | | | | | | |
| **Contact Telephone Numbers:** | | **Landline** | | | | **Work Mobile** | |
|  | | | | | | | |
| **Client Name:** | | | **Date of Birth:** | | | **Gender at birth:**  Male / Female | |
| **Client Address:** | | | | | | | |
| **Client Email:** | | | | | | | |
| **Contact Telephone Numbers:** | | **Mobile** | | | | **Landline** | |
| **Consent to contact:**  (Y / N ) | **Letter** | **Phone** | | **Voicemail** | | **Text** | **Email** |
|  |  | |  | |  |  |
|  | | | | | | | |
| **Substance** *(e.g. alcohol)* | | **Frequency & Quantity** | | | | **Route** | **Age First Used** |
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| **Further information:** *Please include/attach: any significant risks, transfer documents (last TOPs, risk, safeguarding), and current substitute prescribing arrangements, if applicable.* | | | | | | | |
|  | | | | | | | |
| **Please sign to confirm you have the client’s consent to make this referral:** | | | | | | | |

Please email, fax or post to:

South Gloucestershire Drug & Alcohol Service - DHI

Corum 2 Crown Way [SPOC.southglos@dhi.cjsm.net](mailto:SPOC.southglos@dhi.cjsm.net) (if you do not have CJSM email please

Warmley contact the team on the phone number below)

South Gloucestershire TELEPHONE: 01454 868 750

BS30 8FJ FAX: 01179 671 047

FREEPHONE 08000 733 011 (Clients only for self-referral)