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| **Client Details:**  Name: |  | | | | Date Of Referral: | |
| NHS No:  N.I. Number: |  | | | | Date Of Birth: | |
| Address:  (Inc. Postcode) |  | | | | Telephone Numbers  Home:  Mobile:  Other (specify): | |
|  | | | | | | |
| **Referrer Details:**  Name: |  | | Telephone Number:  Email: | | | |
| ProfessionalAddress of Referrer: |  | | | | | |
| **GP Details of Client**  Name/GP Practice: |  | | | Telephone Number: | | |
|  | | | | | | |
| **Substance Use** | **Amount** | **Route (Inject/Smoke/Sniff/Oral/Other)** | | | | **Frequency** |
| Alcohol |  |  | | | |  |
| Amphetamines |  |  | | | |  |
| Cannabis |  |  | | | |  |
| Crack |  |  | | | |  |
| Cocaine |  |  | | | |  |
| Opiates |  |  | | | |  |
| Benzodiazepines |  |  | | | |  |
| Over the counter |  |  | | | |  |
| Other |  |  | | | |  |
| All Prescribed Medication**:** |  | | | | | |
|  | | | | | | |
| **Please Note: If this client is abstinent or using prescribed medication only at the time of referral it is important that you contact us on 01934 427940 for discussion (prior to sending this referral form) so that we may discuss what treatment options are available at WeAreWithYou.** | | | | | | |
|  |  | | | | | |
| Relevant Physical  Health Status: |  | | | | | |
| Relevant Mental Health Status: |  | | | | | |
| Other comments: |  | | | | | |
|  | | | | | | |
| **Client Consent:**  Phone Y/N  Email Y/N (please provide email address if Y)  Letter Y/N  With You may add the information given above onto the WeAreWithYou Data System (also known as Illy CarePath) and may obtain further information from the above referrer if necessary:  Client Signature (verbal consent is accepted):  Print name: ……………………………………………………… Date signed: ………../…….…/………….. | | | | | | |
|  | | | | | | |

**Please complete (client consent must be signed) this form and return to:**

**With You, 35 Boulevard, Weston super Mare, BS23 1PE or to our secure email: withyou.weston@nhs.net**