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| |  | | --- | | G:\LEVEL3\Business Support\Marketing\NEW LOGOS 2017\FINAL ACT LOGOS\ACT_Logo_CMYK.jpg  **Drug and Alcohol Recovery Outreach Service**  **Referral Form**  ***\*Please note that all boxes are mandatory , incomplete referrals cannot be accepted*** |  |  |  | | --- | --- | | **Referring Agency Details *(please print)*** | | | Referring Agency |  | | Date of Referral |  | | Name of Contact |  | | Locality |  | | Telephone Number |  | | Email Address |  | | **Service User Details** | | | Service User Name (AKA) |  | | Address |  | | Contact Number |  | | National Insurance Number |  | | Recommended Contact Method |  | | Alternative Contact (if relevant) |  | | Contact Information (Suitable time to call/good place to meet etc) |  | | Date of Birth |  | | Risk Factors (Alcohol use, drug use mental health issues, violence, known acquaintances etc) |  | | **Details of Dependents *(please complete a separate for each child and continue on ‘other relevant information if necessary)*** | | | Name of Child |  | | Date of Birth |  | | School |  | | Gender |  | | Address |  | | Involvement with CYP (CP/CIN/CAF, category of risk) |  | | Name of Child |  | | Date of Birth |  | | School |  | | Gender |  | | Address |  | | Involvement with CYP (CP/CIN/CAF, category of risk) |  | | **Reason for Referral** | | | Background information – please include details of current alcohol consumption and issues arising from this |  | |  |  | | | | | | | | | | |
| **Has SU given consent for this referral?** | | | | | | | |
| * Yes |  | | | | * No |  | |
| **Are there any current safeguarding concerns?** | | | | | | | |
| * Yes |  | | | | * No |  | |
| **Are there any known criminal convictions? If yes please state below** | | | | | | | |
| * Yes |  | | | | * No |  | |
|  | | | | | | | |
| **Are there any current Probation involvement orders? If yes please state below** | | | | | | | |
| * Yes |  | | | | * No |  | |
|  | | | | | | | |
| Relevant information that may increase risk to the Service User(s) or Professional(s) | | | | |  | | |
| Details of other agencies supporting the Service User | | | | |  | | |
| **Other relevant information** | | | | | | | |
|  | | | | | | | |
| **Equality and Diversity** | | | | | | | |
| Anglia Care Trust is committed to Equality and Diversity. In order to ensure the effectiveness of this policy, all service users are requested to provide the following information. This monitoring form is strictly confidential and this information is used to ensure that access to this service is open and available to all members of the community. | | | | | | | |
| **1. Gender** | | | | | | | |
| * Male | | □ | | * Transgender | | | □ |
| * Female | | □ | | * Prefer not to say | | | |
| **2. Ethnic background** | | | | | | | |
| White | | | | | | | |
| * English/Scottish/Welsh/ Northern Ireland/UK | | □ | | * Gypsy or Irish Traveller | | | □ |
| * Irish | | □ | | * Any other white background | | | □ |
| Mixed ethnic background | | | | | | | |
| * Mixed ethnic background | | □ | |  | | | |
| Asian/Asian British | | | | | | | |
| * Indian | | □ | | * Bangladeshi | | | □ |
| * Pakistani | | □ | | * Chinese | | | □ |
| * Any other Asian background | | □ | |  | | | |
| Black/Black British | | | | | | | |
| * African | | □ | | * Caribbean | | | □ |
| * Any other black background | | □ | |  | | | |
| Other ethnic group | | | | | | | |
| * Arab | | □ | | * Other ethnic group | | | □ |
| * Prefer not to say | | □ | |  | | | |
| **3. Disability** | | | | | | | |
| * Disabled | | □ | | * Prefer not to say | | | □ |
| * Not disabled | | □ | |  | | | |
| **4. Age** | | | | | | | |
| * 0-24 years | | □ | | * 65+ years | | | □ |
| * 25-64 years | | □ | | * Prefer not to say | | | □ |
| **5. Sexual orientation** | | | | | | | |
| * Heterosexual | | □ | | * Gay/Lesbian | | | □ |
| * Bisexual | | □ | | * Prefer not to say | | | □ |
| **6. Religion or belief** | | | | | | | |
| * Christian | | □ | | * Muslim | | | □ |
| * Buddhist | | □ | | * Sikh | | | □ |
| * Hindu | | □ | | * Other religion | | | □ |
| * Jewish | | □ | | * Prefer not to say | | | □ |
| * No religion | | □ | |  | | | |
| **7. How did you find out about our service** | | | | | | | |
| * Local Newspaper | | □ | | * Radio | | | □ |
| * ACT Website | | □ | | * Word of mouth | | | □ |
| * Other (please specify below) | | □ | | * Prefer not to say | | | □ |
| **Confidentiality** *- to be completed by the Service User prior to referral*  I understand that the Referring Agency and Anglia Care Trust will exchange such information as necessary for the purpose of this referral. | | | | | | | |
| Signed - Service User: | | |  | | | | |
| Date: | | |  | | | | |
| Signed – Partner:  *(if applicable)* | | |  | | | | |
| Date: | | |  | | | | |
| **Send completed forms to:** | | | | | | | |
| Anglia Care Trust, 8 The Square, Martlesham Heath, Ipswich, Suffolk IP5 3SL  Tel: 01473 622888 Fax: 01473 618660 Email: [admin@angliacaretrust.org.uk](mailto:admin@angliacaretrust.org.uk) | | | | | | | |

Signature of Referrer: …………………………………………...Date: …………………………

Signature of Service Us………………………………………….Date: …………………………

(Verbal consent is accepted if needed)

|  |
| --- |
| We will treat your information as confidential and we will not share it with any other organisation unless we are required by law to share it or unless you or any other person will come to some harm if we do not share it. In any case we will only ever share the minimum information we need to share. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug & Alcohol Recovery Outreach Service**  **Risk assessment to be completed by referrer** | |  |  |
|  |  | | |

|  |  |  |
| --- | --- | --- |
| REFERRER: | | DATE: |
| SERVICE USER: | | DOB: |
| **Please provide any relevant information to assist us in preparing a Risk Assessment** | | |
| OFFENDING BEHAVIOUR |  | |
| SEXUAL |  | |
| SUBSTANCE MISUSE |  | |
| PHYSICAL & MENTAL HEALTH |  | |
| VIOLENCE & AGGRESSION |  | |
| ASSOCIATES |  | |
| OTHER – PLEASE DETAIL |  | |

**Please complete and send to admin@angliacaretrust.org.uk**