Referral/Self Registration into Specialist Services

|  |  |
| --- | --- |
| **Client Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Contact Number** |  |
| **Email address** |  |
| **GP name** |  |
| **GP Address** |  |
| **Preferred way to be contacted** |  |
| **I “*Client name* ” consent to referral to Horizon drug and alcohol service** | **Signature………………………..**  **Print** |
| **Main substance of misuse** |  |
| **Quantity of substance used?**  E.G. Units of alcohol per day / Cannabis joints per day / Gram of heroin etc |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Check List** | | | |
| Pregnant |  | Injecting drug use |  |
| Domestic Violence |  | Physical health conditions / symptoms |  |
| Mental Health conditions / symptoms |  | Seizures |  |
| Risk of self-harm or suicidal thoughts |  | Learning Disabilities |  |
| Hallucinations |  | Aggression/Violence |  |
| Alcohol more than 40 units daily |  | Probation |  |
| Adult Safeguarding, are you currently working with Adult Social Care? | | | |  |
| Child Safeguarding, are there any children under the age of 18 in the household? | | | |  |
| Are you open to Children’s Services? | | | |  |
| Would you be interested in talking to someone about Horizons employment support service? Yes / No | | | |  |
| Consent to Outreach Yes / No |  |  | |

|  |
| --- |
| **Additional Information (Please expand on any risks indicated on the checklist)** |

|  |  |
| --- | --- |
| **Name of Referrer** |  |
| **Contact details** |  |
| **Date of Referral** |  |
| **Response to Referrer** |  |

|  |  |
| --- | --- |
| **Send via Post** | Horizon, Connect Building , 102 Dickson Road, Blackpool  FY1 2BU |
| **Via Email** | [HorizonReferrals@calico.org.uk](mailto:HorizonReferrals@calico.org.uk) |
| **Telephone** | 01253 205156 |