Referral/Triage Assessment

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This form can be used by Professionals and for Self Referrals

Referral	
Referral Date: Referral Source: Worker Assessing:	Previously accessed treatment? **Yes ☐ No ☐** If "**Yes**" where did you access treatment and when?
Basic Details	
Surname: First Name: Date of Birth: Religion or belief:	Country of birth: Ethnicity: Sexuality: Gender:
Contact Details	**Contact Permissions**
Address: Postcode: Telephone/mobile: E-mail: If NFA name & number where we can contact you? Emergency Contact Details & No (Next of kin):	Permission to contact you using these methods? (Please tick if you consent) **Phone ☐ Text ☐ Post ☐** Permission to record your basic details on Inspire database (CarePath)? **Yes ☐ No ☐** Names of people you consent to discuss your care with and relation?
Housing Details	**Employment Details**
NFA ☐ Housing Problems / Temporary ☐ No Housing Problems / Settled ☐ For NFA clients, details of sleeping sites and link to borough i.e. Probation, GP, Benefits, relatives:	Employment status: ……. If unemployed, time since last employment? ……
GP Details	**Health Details**
Do you have a GP **Yes ☐ No ☐** GP Name: Surgery: Telephone: Is the GP aware of your current use? **Yes ☐ No ☐**	Disability 1: Disability 2: Disability 3: Pregnant: Y / N Due Date: *(if applicable)* Other Health Concerns :

Parental Status

Tick the relevant box below – *Note this only applies to children under 18.*	Are any of the children living with you receiving early help or in contact with social services?
All of the children live with the client ☐	Names & DOB of children:
Not a parent *(of an under 18 yr old)* ☐	
Client declined to answer ☐	
Some of the children live with client ☐	
None of the child live with client ☐	

Presenting Substance Use Profile

(if currently abstinent or on medication please only record problematic substance and not current substitute medication)

Substance	Frequency	Amount per day	Cost	Route	Age 1st used
Primary					
Secondary					
Tertiary					

Ever Injected :

Never ☐ **Currently** ☐ **Previously** ☐ **Declined to answer** ☐

Injected in last month: Y / N
Ever Shared: Y / No

Alcohol Use

Drinking days (per month)	Strength / Type	Number/day	Units/day

Risk

Physical / Mental health concerns: Y / N	A risk of violence from others / DV: Y / N
Pregnant: Y / N	Criminal Justice Contact: Y / N
Suicidal Ideation / Self harm: Y / N	Risk to others: Y / N

Notes:

How did you hear about us? .....

For Professionals: In line with GDPR 2018 please confirm that you have discussed the referral with your client and they have agreed to it being made **Yes** ☐ **No** ☐

Please email form to: referrals@inspirepartnership.org.uk

Or our secure email: referrals@inspirepartnership.org.uk.cjsm.net

If your referral includes concerns regarding alcohol use, it would be extremely helpful if you completed the following Alcohol Audit, so we can identify the best help for you, at Inspire, as quickly as possible.

Alcohol Audit

This is one unit of alcohol:

and each of these is more than one unit of alcohol:

Audit Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: 0–7 Lower Risk, 8–15 Increasing Risk, 16–19 Higher Risk, 20+ Possible Dependence				**Total score:**		