**ARC-MK Referral Form**

|  |  |
| --- | --- |
| Referral Date |  |

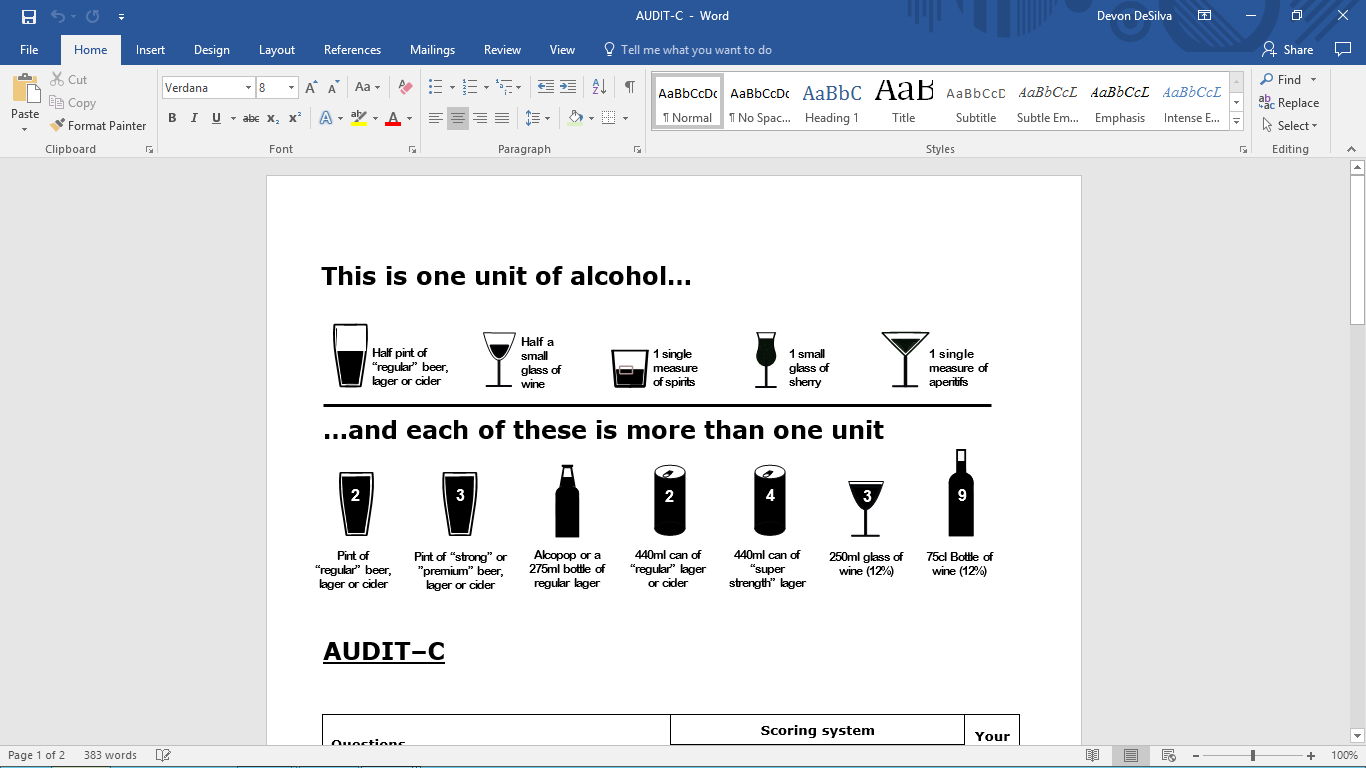
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | |
| Agency Name |  | Worker Name | | |  | | |
| Agency Type |  | | | | | | |
| Agency Address |  | | | | | | |
|  | | | | | Postcode |  |
| Telephone |  | | Fax |  | | | |
| Email |  | | | | | | |
| Reason for Referral |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service User Details** | | | | | | | | | | | | | | | | | | |
| Title |  | | | | First Name | | |  | | | | Last Name | | |  | | | |
| NHS No. |  | | | | N.I. No. | | |  | | | | Date of Birth | | |  | | | |
| Address |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Post code | |  | | | | | | | | Can we contact service user at this address? | | | | Yes | |  | No |  |
| Landline number | |  | | | | | | | | Can we contact service user on this number? | | | | Yes | |  | No |  |
| Mobile number | |  | | | | | | | | Can we contact service user on this number? | | | | Yes | |  | No |  |
| Email Address | |  | | | | | | | | Can we contact service user on this e-mail? | | | | Yes | |  | No |  |
| Client Gender | | Male |  | Female | |  | Not known | |  | Not specified |  | | Ethnicity | |  | | | |
| Housing Needs | | Specify current living situation | | | | | | | | | | | | | | | | |

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| **GP Details** | | | |
| GP Name |  | Address |  |
| Postcode |  | Telephone Number |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Supporting Access to Services** | | | | | | | | | | | |
| Does the service user understand spoken English? | Yes |  | No |  | Does the service user understand written English? | | | Yes |  | No |  |
| Is an Interpreter needed? | Yes |  | No |  | If yes, please specify language: |  | | | | | |
| Does the service user have a Physical Disability? | Yes |  | No |  | Please provide details of support that may be required for the client to access the service: | |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance Misuse** | | | |
|  | Drug name | Frequency of use | Method of use if known  (smoke/inject/ingest) |
| Primary substance |  |  |  |
| Secondary substance |  |  |  |



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT-C** | | | | | | |
| **Questions** | **Scoring system** | | | | | **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? | 0 - 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 |  |
| Scoring  A total of 5+ indicates increasing or higher risk drinking.  An overall total score of 5 or above is AUDIT-C positive. | **AUDIT-C Score** | | | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Risk Screen** | | | | | | |
| Pregnancy |  | Safeguarding Children / Childcare Concern | |  | Injecting Drug Use |  |
| Physical Health Concerns |  | Safeguarding Adult Concern | |  | Suicide Risk |  |
| Mental Health Concerns |  | Domestic Abuse | |  | In Prison Custody |  |
| Homelessness |  | Other please specify: |  | | | |
| Are there any other risk concerns to note? | | | | | | |

**Please return via post or email:**

ARC-MK

33-37 Farthing Grove

Netherfield

Milton Keynes

MK6 4JH

**Email:** cnwl.arc-mk@nhs.net

**For any queries please contact us at:**

Tel: 01908 250730

For ARC-MK use only

Date Referral was Received: …………………………………… Referral Received by: ……………………………………………….