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| **Client Details** |
| Forename: …………………………………………… Surname: ……………………………………………… Gender: Male / Female  DOB: ….... / ….... / …………… Is their age at referral either: Under 25 □ Over 65 □  Ethnicity: ………………………………………… Nationality: ………………..…………….. Marital Status: ……………………………………….. |
| **Primary Contact Details – *They must have York as their Local Authority for us to work with them*** |
| Address: ………………………………………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………… Postcode: ………………………………  Contact Numbers: ……………………………………………………………………………………………………………………………………………………….  Email: ………………………………………………………………………….. Can we contact by: Address □ Telephone □ Text □ Email □  How did you hear about us? …………………………………………………………………………………………………………………………………….. |
| **GP Details** |
| GP Name: …………………………………………………………………………… Tel No: …………………………………………………………………….  GP Address: ……………………………………………………………………………………………………………………………………………………………  Are we able to share information with your GP: Y / N Do you see your GP regularly for your healthcare? Y/N |
| **Referrer Details** |
| Name: …………………………………………………………….. Tel No: …………………………………… Fax No: ……………………………………………  Agency and Address: ……………………………………………………………………………………………………………………………………………………  Email: ……………………………………………………………………………………. Has the client consented for this referral: Y / N |
| **Previous Treatment** |
| Have you been in treatment before? If Yes, what type of treatment have you received? (check for Changing Lives/Oaktrees)  ……………………………………………………………………………………………………………………………………………………………………………………. |
| **Substance Profile – Primary Substance Used - Route: Inject □ Sniff □ Smoke □ Oral □ Other □** |
| **Make sure you assess Type, Level, Age First Used and Duration Drug □ Alcohol □ Combination □** |
| **Substance Profile – Secondary Substance Used - Route: Inject □ Sniff □ Smoke □ Oral □ Other □** |
| **Make sure you assess Type, Level, Age First Used and Duration Drug □ Alcohol □ Combination □** |
| **Substance Profile – Third Substance Used - Route: Inject □ Sniff □ Smoke □ Oral □ Other □** |
| **Make sure you assess Type, Level, Age First Used and Duration Drug □ Alcohol □ Combination □** |
| **Additional information – Any other relevant information you feel may be of use.** |
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| **Health Profile** | |
| Do you have any communication or support needs we need to be aware of? If Yes please state:  Do you have any medical conditions we should be aware of (physical or mental health related)? If Yes please state:  Have you ever been immunised against Hepatitis B, or tested for Hepatitis B, C or HIV? If Yes please state the details below:  Are you a smoker? Y / N (Please circle one answer) | |
| **Parental Status** | |
| Is the client a Parent? Y / N (if Y ensure full names/DOB/Address are collected at assessment)  Currently Pregnant: Y / N | |
| **Safeguarding / Risk** | |
| Please identify any known safeguarding issues or risks – If unknown this will be completed at assessment. | |
| **Social Profile** | |
| Accommodation Status: ………………………………………………….. Employment Status: ………………………………………………………..  Have you ever received a day’s pay from the armed forces? Y / N | |
| **Criminal Justice** | |
| Have you had any contact with Criminal Justice services in the last six months? Y / N  If they answer yes then ask what was their most recent offence that they were arrested for was and specify this and also the name of their probation officer. If with Probation needs worker to request OASYS risk assessment from Probation. | |
| **Availability of Appointments** | |
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| **Assessment Appointment Date – Remind client that this assessment can last up to 90 minutes** | |
|  | |
| **Notes** | |
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| **Please send your referral through to** | |
| **Postal Address:**  Blossom Street Service  3 Blossom Street  York  YO24 1AU | **Telephone:** 01904 464680  **Fax:** 01904 464688  **Secure Email:** blossomstreet.admin@changinglives.cjsm.net |