

The Drug and Alcohol Wellbeing Network, West Sussex.

Referral Form		
What would you like to achieve by engaging with us?		
How did you hear about the service?		Date of referral:
<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms Other:	First name:	D.O.B:
	Surname:	Age:
Address and Postcode		Telephone number:
		Mobile number:
Email address:		
NHS Number:		
Gender: What gender do you currently identify as? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say If you prefer to use your own term please provide it here:	Relationship: <input type="checkbox"/> Single <input type="checkbox"/> With a partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Partnership <input type="checkbox"/> If you prefer to use your own term please provide it here:	Sexual Orientation: <input type="checkbox"/> Gay Women/Lesbian <input type="checkbox"/> Gay Man <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Unsure <input type="checkbox"/> Prefer not to say If you prefer to use your own term please provide it here:
Nationality: <input type="checkbox"/> British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Irish	<input type="checkbox"/> Jamaican <input type="checkbox"/> Polish <input type="checkbox"/> French <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Latvian	<input type="checkbox"/> Lithuanian <input type="checkbox"/> Russian <input type="checkbox"/> German <input type="checkbox"/> Other If other please provide details:
Ethnic Origin: <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> Other White <input type="checkbox"/> White & Black <input type="checkbox"/> Caribbean <input type="checkbox"/> White & Black African	<input type="checkbox"/> White & Asian <input type="checkbox"/> Asian/Asian British Indian <input type="checkbox"/> Asian/Asian British Pakistani <input type="checkbox"/> Asian/Asian British Bangladeshi <input type="checkbox"/> Asian/Asian British Other <input type="checkbox"/> Other Mixed <input type="checkbox"/> Black/Black British Caribbean	<input type="checkbox"/> Black/Black British African <input type="checkbox"/> Other – Chinese <input type="checkbox"/> Traveller/Gypsy <input type="checkbox"/> Other If other please provide details:
Religion: <input type="checkbox"/> Baha'i <input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Jain <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim	<input type="checkbox"/> Pagan <input type="checkbox"/> Sikh <input type="checkbox"/> Zoroastrian <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Prefers not to say <input type="checkbox"/> Unknown	Language: Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you require support through a British Sign Language Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider yourself to have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please provide details		



Employment Status: <input type="checkbox"/> Regular employment <input type="checkbox"/> Long term illness <input type="checkbox"/> Student <input type="checkbox"/> Ex Armed Services <input type="checkbox"/> Unpaid work (voluntary) <input type="checkbox"/> Unemployed (receiving no benefits) <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed (seeking work) <input type="checkbox"/> Retired <input type="checkbox"/> Other		Accommodation Status: <input type="checkbox"/> Problem with Housing <input type="checkbox"/> No housing problem <input type="checkbox"/> Homeless Please provide details:
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Smoking Status: <input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> Never	Currently pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Partner currently pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
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Next of Kin: (we will only contact his person in a case of an emergency)

Do you consent to us sharing information with this person? Yes No

Drug and/or Alcohol Use

Main substance of choice: Age First Used: How do you use: <input type="checkbox"/> Inject <input type="checkbox"/> Sniff <input type="checkbox"/> Smoke <input type="checkbox"/> Oral <input type="checkbox"/> Other	How often do you use? How much do you use? How much do you spend a week on this substance?
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Second substance of choice: Age First Used: How do you use: <input type="checkbox"/> Inject <input type="checkbox"/> Sniff <input type="checkbox"/> Smoke <input type="checkbox"/> Oral <input type="checkbox"/> Other	How often do you use? How much do you use? How much do you spend a week on this substance?
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Third substance of choice: Age First Used: How do you use: <input type="checkbox"/> Inject <input type="checkbox"/> Sniff <input type="checkbox"/> Smoke <input type="checkbox"/> Oral <input type="checkbox"/> Other	How often do you use? How much do you use? How much do you spend a week on this substance?
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Alcohol Use: Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously At what age did you first drink alcohol?	If yes how often do you drink alcohol? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly When was the last time you had a drink of alcohol?
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Do you use Novel Psychoactive Substances (Legal/Illegal Highs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously If yes please list:	Do you use any volatile substances? (Gas, Glue, Aerosols) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously If yes please list:
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<p>Do you use Steroids or any other image/performance enhancing drugs?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously If yes please list:	<p>Do you use any over the counter medications (such as Co-codamol, Paracetamol)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously If yes please list:												
<p>Injecting:</p> <p>Have you ever injected drugs:</p> <input type="checkbox"/> Never injected <input type="checkbox"/> Previously injected <input type="checkbox"/> Currently inject <p>If you have previously injected drugs: At what age did you first inject?</p> <p>Have you injected in the last 28 days?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No													
<p>Have you ever shared injecting equipment?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Have you shared injecting equipment in last 28 days?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Have you ever allowed someone else to inject you?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No													
<p>Criminal Justice:</p> <p>Are you currently working with Criminal Justice Services (e.g. police, probation, prisons)?</p> <input type="checkbox"/> No If no please go to next section <input type="checkbox"/> Yes <p>If yes, what prompted the contact?</p> <table border="0"> <tr> <td><input type="checkbox"/> Required Assessment Imposed Following Positive Test</td> <td><input type="checkbox"/> Restriction On Bail</td> </tr> <tr> <td><input type="checkbox"/> Conditional Cautioning</td> <td><input type="checkbox"/> Pre-Sentence Report</td> </tr> <tr> <td><input type="checkbox"/> Required by Offender Management Scheme/DRR/ATR</td> <td><input type="checkbox"/> Voluntary – Following Release From Prison</td> </tr> <tr> <td><input type="checkbox"/> Voluntary – Following Cell Sweep</td> <td><input type="checkbox"/> Voluntary – Other</td> </tr> <tr> <td><input type="checkbox"/> Following Referral by Treatment Provider (Post Treatment)</td> <td><input type="checkbox"/> Requested By Offender Manager</td> </tr> <tr> <td><input type="checkbox"/> Rehabilitation Activity Requirement (RAR)</td> <td><input type="checkbox"/> Other</td> </tr> </table>		<input type="checkbox"/> Required Assessment Imposed Following Positive Test	<input type="checkbox"/> Restriction On Bail	<input type="checkbox"/> Conditional Cautioning	<input type="checkbox"/> Pre-Sentence Report	<input type="checkbox"/> Required by Offender Management Scheme/DRR/ATR	<input type="checkbox"/> Voluntary – Following Release From Prison	<input type="checkbox"/> Voluntary – Following Cell Sweep	<input type="checkbox"/> Voluntary – Other	<input type="checkbox"/> Following Referral by Treatment Provider (Post Treatment)	<input type="checkbox"/> Requested By Offender Manager	<input type="checkbox"/> Rehabilitation Activity Requirement (RAR)	<input type="checkbox"/> Other
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<p>What is the date of the event that prompted your contact with criminal justice services?</p> <p>What is the offence?</p> <p>If you have recently been released from prison, what date were you released and from which prison?</p>													
<p>Offender Management Schemes / Orders:</p> <input type="checkbox"/> Integrated Offender Management (IOM) <input type="checkbox"/> Required Activity (RA) <input type="checkbox"/> Prolific and Priority Offender (PPO) <input type="checkbox"/> Multi-agency Public Protection Arrangements (MAPPA) <input type="checkbox"/> Restriction on Bail (ROB)													
<p>If you are completing this form for yourself you don't need to do this section:</p> <p>Referrer details:</p> <p>Name and job title:</p> <p>Agency:</p> <p>Preferred means of contact:</p> <p>Is the person you are referring motivated to engage in this service? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please comment:</p> <p>Would you like feedback on the outcome of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>													

Please send your completed referral to westsussex.contact@cgl.org.uk or westsussex.contact@cgl.cjsm.net *secure, or any of the locality emails if you know which area you require, i.e. CoastalDawn@cgl.cjsm.net or WestDawn@cgl.cjsm.net or NorthDawn@cgl.cjsm.net.