

# Referral Form

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

DOB: \_\_\_\_\_ M / F

Referral date: \_\_\_\_\_

TOPS Y / N      Date Completed: \_\_\_\_\_

**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Postcode:**

**Contact No:** \_\_\_\_\_

**Country of Birth**

\_\_\_\_\_

**Faith**

\_\_\_\_\_

**Sexuality**

\_\_\_\_\_

**Ethnicity**

- |               |                          |                         |                          |
|---------------|--------------------------|-------------------------|--------------------------|
| White British | <input type="checkbox"/> | White & Black Caribbean | <input type="checkbox"/> |
| White Irish   | <input type="checkbox"/> | White & Black African   | <input type="checkbox"/> |
| Other White   | <input type="checkbox"/> | White & Asian           | <input type="checkbox"/> |
| Indian        | <input type="checkbox"/> | Other Mixed             | <input type="checkbox"/> |
| Pakistani     | <input type="checkbox"/> | Caribbean               | <input type="checkbox"/> |
| Bangladeshi   | <input type="checkbox"/> | African                 | <input type="checkbox"/> |
| Other Asian   | <input type="checkbox"/> | Other Black             | <input type="checkbox"/> |
| Chinese       | <input type="checkbox"/> | Other                   | <input type="checkbox"/> |

**Has the client ever injected?**       Never  
 Currently  
 Previously

- Referral Service:**
- RDAS
  - Redbridge DIP
  - Self

**Other:** \_\_\_\_\_

**Worker:** \_\_\_\_\_

**Tel:** \_\_\_\_\_

	Yes	No
Previous Treatment (Tier 3 or 4)	<input type="checkbox"/>	<input type="checkbox"/>
Currently on Substitute Prescription	<input type="checkbox"/>	<input type="checkbox"/>
DIP	<input type="checkbox"/>	<input type="checkbox"/>
DRR	<input type="checkbox"/>	<input type="checkbox"/>
Tier 2	<input type="checkbox"/>	<input type="checkbox"/>
Registered with a GP	<input type="checkbox"/>	<input type="checkbox"/>
Dual Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>

**Accommodation Need**

- NFA Urgent Housing Problem
- Housing Problem
- No Housing Problem

**Parental Status**

- Children living with client
- Children living with partner
- Children living with other family member
- Children in care
- Client pregnant
- Other

	Current Substance	Age of first use	Route
1st			
2nd			
3rd			