# Referral Form

71-73 The Broadway | Southall | UB1 1LA

| **Referral Criteria – must have a minimum of 3 complex needs identified:** | | | |
|---|---|---|---|
| **Substance Misuse** ☐ | **Mental Health** ☐ | **Domestic Abuse** ☐ | |
| **Offending Behaviour** ☐ | **Prostitution/Trafficking** ☐ | | |
| Email referral form to **wwz@cgl.org.uk**<br>If you wish to discuss the referral or have any questions, please contact Sukhy Hira directly on 07392317250. | | | |

| **Details of Referring Service** | |
|---|---|
| Service: | Assessor's Name |
| Telephone Number: | Designation/Job Role: |
| Email Address: | Date Referral Sent: |

| **Service User Details:** | | | | |
|---|---|---|---|---|
| First name(s): | | | | Address: |
| Last name: | | | | |
| Date of Birth: | | Age: | | Postcode: |
| Gender at Birth (please tick) | Male ☐ | Female ☐ | Other ☐ | NHS number (if known): |
| Ethnicity: | | Nationality: | | Borough of Residence: |
| Religion: | | Marital Status: | | Sexual Orientation: |
| Contact Telephone Number(s)<br>Home: | | | | Mobile:<br>Does the service user consent to WWZ texting this number? Yes ☐ No ☐ |

Does the service user require any communication support? Yes ☐ No ☐

e.g. language interpreter or sign language communication

If yes, please specify:

| **General Practitioner (GP) details** |
|---|
| Please tick from the following:<br>Registered with a GP ☐ Not registered with a GP ☐ Unable to register with a GP ☐ |

| GP Name: | Surgery Name: |
|---|---|
| GP Address | |
| Contact Number: | Ealing GP Yes ☐ No ☐ |

| **Drug and/or Alcohol Use** | |
|---|---|
| **Main Substance of Choice:**<br><br>Age First Used:<br><br>How do you use:<br>☐Inject<br>☐Sniff<br>☐Smoke<br>☐Oral<br>☐Other | How often and how much does the service user use?<br><br>How long has the substance used been a problem for the service user? |
| What other substance(s) is the service user currently using (illicit/prescribed)?<br><br>How often and how much does the service user use? How long has the substance(s) used been a problem for the service user? | |
| Is the Service User on any prescribed medication? If yes, please give details: | |
| **Alcohol Use:**<br>Does the service user drink alcohol?<br>☐ Yes<br>☐ No<br>☐ Previously | If yes how often does the service user drink alcohol?<br>☐ Daily<br>☐ Weekly<br>☐ Monthly<br>☐ Less than monthly |
| **Identification of Support Issues and Risk Factors** | |
| Mental Health Issues ☐ **Y** ☐ **N**<br><br>Please specify diagnosis, whether engaging with mental health services and any prescribed medication: | Physical Illness ☐ **Y** ☐ **N**<br><br>If yes, please provide details: |
| Criminal Justice Involvement ☐ **Y** ☐ **N** | Disability ☐ **Y** ☐ **N** |

| | |
|---|---|
| If yes, please provide details: | If yes, please provide details: |
| Pregnant ☐ **Y** ☐ **N**<br><br>Please provide details (trimester etc): | Social Services contact ☐ **Y** ☐ **N**<br><br>Please provide details (named professional): |
| At risk of harm from others (violence/domestic abuse) ☐ **Y** ☐ **N**<br><br>Please provide details:<br><br>Referred to MARAC ☐ **Y** ☐ **N**<br><br>Service User aware of Referral ☐ **Y** ☐ **N** | At risk of harm to others (violence/domestic abuse) ☐ **Y** ☐ **N**<br><br>Please provide details: |
| Current self-harm/suicide ☐ **Y** ☐ **N**<br><br>Please provide details: | A parent/primary carer to child(ren) under 18 ☐ **Y** ☐ **N**<br><br>Please provide details: |
| Lives with child(ren) under 18 ☐ **Y** ☐ **N**<br><br>Please provide details: | Is a carer for an adult dependant ☐ **Y** ☐ **N**<br><br>Please provide details: |
| Other Agencies Involved ☐ **Y** ☐ **N**<br><br>Please provide details: | |

| **Client consent** | | |
|---|---|---|
| Does the service user give their consent for being referred to WWZ | Yes ☐ | No ☐ |
| Can the Service write to the service user at the given address? | Yes ☐ | No ☐ |
| Can Services leave messages on the numbers that have been given? | Yes ☐ | No ☐ |

| | |
|---|---|
| If no to the above, how can the Service arrange to contact the service user? | |
| I give my consent to share information that has been given on the form with WWZ in order to access their Service | |
| Signature | Date |

## Additional Notes of Relevance