

 ICAS Referral Form

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| Service User Name:  | DOB:  |
| Name of referrer and organisation:   | Referral Date:  |
| Consent, Contact and Confidentiality Form explored and completed? YES / NO \*If no, reason  |
| Welcome to ICAS:  |
| * Mr
* Mrs
* Miss
* Ms Other:
 | First name:  | D.O.B:  |
| Surname:  | Age:  |
| Address and Postcode   | Telephone number   |
| Mobile number  |
| NHS number  |
| Email address:  |
| Gender: What gender do you currently identify as? * Male
* Female
* Prefer not to say or not specified

If you prefer to use your own term please provide it here:    | Relationship: * Single
* With a partner
* Married
* Separated
* Widowed
* Divorced
* Civil Partnership
* If you prefer to use your own term please provide it here:

  | Sexual Orientation: * Bisexual
* Gay or Lesbian
* Heterosexual
* Not known
* Other, not listed
* Person asked and does not know
* Prefer not to say

If you prefer to use your own term please provide it here:   |
| Nationality:  Jamaican Lithuanian  Russian * British  Polish
* Indian  French
* Pakistani  Bangladeshi
* Irish  Latvian
* Not stated  German

 Other * If other please provide details:
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| Ethnic Origin:  Asian/Asian British Indian  Mixed - White & Black African * White British  Asian/Asian British Pakistani  Mixed - White & Black Caribbean
* White Irish  Asian/Asian British Bangladeshi  Not stated
* Other White  Asian/Asian British Other  Other
* Black/Black British -  Chinese If other, please provide details:
* Caribbean  Ethnicity is unknown
* Black/Black British – African

 Mixed – other mixed * Black/Black British - other

 Mixed – White and Asian   |
| Religion: * Baha’i  Hindu
* Jain  Sikh
* Christian  Pagan
* Muslim  Buddhist
* Zoroastrian Other, Please state:

 Jewish  None Declines to disclose Unknown   |

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|  Disability; please identify disability one, two, three:  ☐ Acquired brain injury ☐ Mental health difficulties  ☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Mobility impairment  ☐ Autism/Asperger’s Syndrome ☐ No disability  ☐ Cerebral Palsy ☐ Not stated  ☐ Dementia ☐ Other disability  ☐ Dyslexia ☐ Perception of physical danger  ☐ Hearing impairment ☐ Personal self-care and continence  ☐ Learning difficulty ☐ Physical disability  ☐ Learning disability ☐ Progressive conditions and physical health  ☐ Literacy impairment ☐ Sight impairment  ☐ Manual dexterity ☐ Speech impairment  |
| Registered with a GP:  Yes  No Current/last known GP name and details:     |
| Consent  |
| ICAS are bound by laws, regulations and organisational values which inform how we use any information about you. To ensure that we can offer, and remind you of, appointments with ICAS we require permission to contact you and also your preferences for how you would like to be contacted. Please tick here if you have been made aware and consent to ICAS contacting you ☐ Please tick all that apply for your preferred contact methods:  ☐ phone call ☐ voicemail ☐ text ☐ email ☐ letter ☐ Home Visit ICAS will keep your information confidential within the service provision you are accessing - unless you give us permission to share information. The only time we may breach your confidentiality without consent is if we are concerned that someone else is at significant risk of harm, such as a child/children or other vulnerable persons, or you yourself are at significant risk of harm. In such instances we will seek to inform you before we share information. Please tick here to confirm you have been made aware of this ☐  In the event that this session leads us to agreeing that another service/services are best placed to support you, we will need to share information about you with them to make a referral\* Please tick here if you have been made aware and consent to this ☐ \*(name/type of service will be agreed at the end of the triage)   |
| Who would you like us to contact in case of an emergency?    |
| Have you ever received structured drug or alcohol treatment from this or any other treatment provider? ☐ Yes ☐ No If yes, please provide details:  Do you currently receive any support or work with any other provider? ☐ Yes ☐ No If yes, please provide details:   |
| Are there any other health issues (pregnancy/mental health) you can tell us about?    |
| Are you currently serving or have served in the UK Armed Forces (Royal Navy, Royal Air Force, and Army (including part time/reservist)? ☐ Yes ☐ No If yes, please provide details   |

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| Summary of Alcohol / Alcohol and Drug Use  |
| In order to support you, we need to understand your Alcohol and/or drug use in a bit of detail, the following , the following information will enable us to agree how we can best meet your needs:   |
| Alcohol Route of administration: ☐ Oral ☐ Other Age of first use: How often do you use?  |
| Drug/Alcohol 2: Route of administration: ☐ Inject ☐ Sniff ☐ Smoke ☐ Oral ☐ Other Age of first use: How often do you use?  |
| Do you currently look after anybody else (children or adults) in a paid or voluntary capacity? ☐ Yes ☐ No If yes, please provide further details:    Are you currently worried about your safety or the safety of someone else you know? ☐ Yes ☐ No If yes, please provide further details:   Please email the come completed referral form to our secure email: camden.referrals@cgl.org.uk or contact us on Tel: 020 32274950 Fax: 020 3227 4959 for more info. Once the referral has been received our referral worker will make three telephone attempts and offer two assessment appointments by letter to the patient in order to engage them and will notify you of the outcome. |