|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Community Provider  MDT Confirmation Form  Community Providers - Please complete this following a local Multi-Disciplinary/Clinical Review of your referral to detox for the West Midlands Framework  Please complete and send with signature to [WestMidsDetoxReady@cgl.org.uk](mailto:WestMidsDetoxReady@cgl.org.uk)  No later than 3 weeks prior to detoxification placement or at point of referral | | | | | | | | | | | | |
| This section is to be completed by the lead nurse or manager responsible for authorising sign off of referrals | | | | | | | | | | | | |
| Name of Clinician/Manager: | | | | | | | Community provider: | | | | | |
| Name of service user: | | | | | | | Service user’s date of birth: | | | | | |
| Date of MDT meeting approving detox: | | | | | | |  | | | | | |
| Reason for inpatient detox or stabilisation (tick those that are relevant): | | | | | | | | | | | | |
| Alcohol Detoxification | | | |  | | Opiate Detoxification | | | | | |  |
| Opiate Stabilisation | | | |  | | Benzodiazepine reduction/detoxification | | | | | |  |
| GBH Detoxification | | | |  | | GBL Detoxification | | | | | |  |
| Detox from synthetic cannabinoids | | | |  | | Stabilisation/detox multiple substances | | | | | |  |
| Any additional needs (Tick those relevant): | | | | | | | | | | | | |
| History of epilepsy | | | | 🞏 | | Learning disability | | | | | | 🞏 |
| Experience of withdrawal-related seizures | | | | 🞏 | | Cognitive impairment related to alcohol dependence | | | | | | 🞏 |
| Experience of delirium tremens (DT’s) | | | | 🞏 | | Previous failed home assisted withdrawal | | | | | | 🞏 |
| Poly-substance misuse | | | | 🞏 | | Lack of reliable home support | | | | | | 🞏 |
| Significant psychiatric problems | | | | 🞏 | | Pregnant | | | | | | 🞏 |
| Significant physical co-morbidities | | | | 🞏 | | Preparation for residential rehabilitation placement. | | | | | | 🞏 |
| Other: Please note below | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Please confirm that the following documents can be provided if required: | | | | | | | | | | | | |
| Risk assessment | 🞏 | | Date: | | Aftercare plan | | | | | 🞏 | Date: | |
| Discharge/Contingency plan | 🞏 | | Date: | | GP Summary | | | | | 🞏 | Date: | |
| Alcohol only: Blood results (last 8 weeks) | 🞏 | | Date: | | Drugs only: Urine test results | | | | | 🞏 | Date: | |
| Please provide the latest SADQ and AUDIT scores (alcohol detox only): | | | | | | | | | | | | |
| Latest SADQ score:  Please enter here \_\_\_\_\_\_\_ | 🞏 | | Date: | | Latest AUDIT score: Please enter here: \_\_\_\_\_\_\_ | | | | | 🞏 | Date: | |
| I confirm that the referral is complete and contains the above documents. I understand that referral may be returned or delayed if incomplete. | | | | | | | | | | | | |
| Name of authorised approver: | |  | | | | | | Position: |  | | | |
| Signature: | |  | | | | | | Date: |  | | | |