|  |
| --- |
| Community ProviderMDT 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 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: |  |