Liverpool Recovery Services Referral Form

ALL SECTIONS OF THE REFERRAL FORM IS TO BE COMPLETED WITH AS MUCH INFORMATION AS POSSIBLE FOR US TO MAKE AN INFORMED DECISION.

This referral form should be used to make a referral to either the 18 week rehabiliation service or the step down, abstinence service. We will acknowledge receipt of your referral within 24 hours and confirm an assessment date within 5 working days. Please indicate which service you wish to be considered for:

Rehabiliation Service □
Abstinence Service □
Community Rehab □
All □

The criteria for the rehabilitation service will be as follows:

a) Are aged 18 years or over
b) Normally live within Liverpool City Council's boundary
c) Are at least 24 hours drug and alcohol free
d) Have a desire to remain abstinent in the long term
e) Have needs that cannot be met in a community setting

The criteria for the abstinence service will be as follows:

a) Are a single and aged 18 years or over
b) Normally reside within the boundary of Liverpool City Council
c) Are already abstinent
d) Have no immediate access to settled accommodation
e) Priority will be given to rough sleepers and people identified as homeless or at risk of homelessness.

The criteria for the community rehabilitation day service will be as follows:

a) Are aged 18 years or over
b) Normally reside within the boundary of Liverpool City Council
c) Are at least 24 hours drug and alcohol free
d) Have a desire to remain abstinent in the long term
e) Have attended the pre-treatment programme
f) Are housed in appropriate and stable accommodation – this includes people who are in temporary accommodation who are stable
g) Have the ability to attend a 48-day treatment programme
h) Commit to attending a minimum of three fellowship or mutual aid meetings per week, throughout treatment

Please tell us why are you considering entering recovery services at this time and which service is your preference and why?
Do you have a plan in place once your treatment comes to an end? Please tell us about youraccommodation options, support networks etc

Information Required for referral to RISE Rehabilitation Service

This service is a residential treatment service, the programme runs from 8:45 am until 8pm with a variety of different therapeutic interventions and activities. There are set guiding principles for the service which include, a commttment to remain drug and alcohol free, to hand your mobile phone in, to not form special relationships whilst in service, to not leave the service unaccompanied and to take part fully in the programme. You must be motivated and willing to remain free of substances for the 18 weeks.

Why do you want to attend residential rehabilitation?
What prevents you from working on your recovery in the community?
What are the things that you think are most important for you to achieve and maintain recovery?
What are the things that may get in the way of your recovery?
If you are accepted into the service you will need to comit to attending a Prehab Group at The Brink once a week. For the first two weeks in service you will not be able to have your moblile phone, you will not be able to leave the service unless for pre-arranged appoitnments and you will be accompanied, you will not be have any visitors to the service. Are you willing to make this commitment?

Please complete **ALL** sections

Referral Form Completed by: Date: Time:

This form has been completed with the client's knowledge and consent? Yes □ No □

SOME BASIC INFORMATION ABOUT YOU (CLIENT)

Full name: Date of Birth: Gender: **M** **F**

Address: Is this : owned / rented / supported housing / temporary

Can you return to this accommodation after treatment? Yes / No

Daytime phone:

Mobile:

What is your ethnic background: *For auditing purposes, we are asked by Health Authorities to record the ethnic origin of those we treat. The categories are those used in the UK census. Which category describes you best:*

White British	White & Black Caribbean	Indian/Indian British	Black Caribbean/Black Caribbean British
White Irish	White & Black African	Pakistani/Pakistani British	Black African/Black African British
Other White	White and Asian	Bangladeshi/Bangladeshi British	Other Black/Black British
Other Mixed	Other Ethnic	Other Asian/Asian British	Chinese

What is your nationality:

How did you hear our services?

Which drugs do you use *(in order of preference)*	How long have you used it for?	How old were you when you first used it?	Have you ever injected?	Have you ever shared needles?

If alcohol: How many days in the last 14 have you consumed alcohol? Units per day?

Have you been abstinent at all? No / Yes - How long was this for *(how many days or weeks):*

How did you achieve this?

Is your treatment service aware of this referral? If not please disucss it with them.

Have you recently engaged with other addiction services?	Please name these services	When did you attend?	What was the outcome?
No / Yes			

Have you attended any mutual aid groups in the past for example NA, AA or SMART?

How often do/did you go?

If you have never been to a meeting, how do you feel about attending in the future?

If you are working with a treatment service for your drug and alcohol use do they know about this referral?

Are you currently: Single / In a relationship / Co-habiting / Civil Partnership / Married / Separated / Divorced / Widowed

Do you have any children? No / Yes If Yes, how many? How old are they?

Who do the children live with?

Are you: Unemployed / Employed P/T / Employed F/T / Self employed

Do you currently receive any benefits? No / Yes – which:

Do you have any concerns about your physical health? No / Yes - please give some brief details:

Are you or have you been involved with the Community Mental Health Services? No / Yes - please give some brief details including any diagnosis you may have been given:

Do you have any additional needs we can support you with? No / Yes
If yes, what are these additional needs?

Please tell us about any medication you are currently taking: *(please check the spelling of medication names)*

What is it called?	How much do you take	How often do you take it	How long have you taken it for	Why are you taking it?	Is it prescribed for you

Do you have any problems with mobility? No / Yes – please describe:

Are you Registered Disabled? No / Yes – what is the nature of your disability?

Name of Referrer:	**Your GP's Name:**
Name of Referring Agency:	Your GP Address:
Agency Address:	
Email:	
Phone:	Phone:
Do you have any outstanding legal convictions? No / Yes	**Your Probation Officer's name:**
Brief Details:	Address:
	Phone:

Agreed OK for Assessment : No / Yes **Day / Date:** **Time:**

REFERRAL CHECKLIST

Detox discussed	☐	Benefits OK	☐
Accommodation requirements checked	☐	Childcare discussed	☐
Commitment to Abstinence	☐	Engagement in Fellowship or SMART	☐

WELLBEING QUESTIONS

Please tick the box that best described your experience relating to each of the following statements over the last 2 weeks.

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	☐	☐	☐	☐	☐
I've been feeling useful	☐	☐	☐	☐	☐
I've been feeling relaxed	☐	☐	☐	☐	☐
I've been dealing with problems well	☐	☐	☐	☐	☐
I've been thinking clearly	☐	☐	☐	☐	☐
I've been feeling close to other people	☐	☐	☐	☐	☐
I've been able to make up my mind about things	☐	☐	☐	☐	☐

INFORMATION CONSENT

By signing here you authorise YMCA Liverpool & Sefton & New Start to store the information you have provided in the DAVE and NDTMS databases, in line with our confidentiality and data protection policies. This is used for internal reporting and service evaluation, and to allow the project to provide (anonymous) statistical data to the National Drug Treatment Monitoring System and Liverpool City Council. You also consent to our staff contacting other appropriate agencies involved in your referral and admission.

Information that you provide to us may be shared with any or all the organisations set out overleaf for the purpose of providing support services to you. This information will include an assessment of your needs/risks and the support that is provided to you. Your data will be stored and retainedon the IT systems we use (DAVE and MainStay) and in paper form in your file for a maximum period of 7 years from your last contact with us.

We do not share or disclose any of your personal information without your consent, other than for the purposes specified in this notice or where there is a legal requirement.

I confirm that this referral is being made with my consent and that the answers are mine.

Signed by Referral/Client …… Date:……

Print name of Client : ……

Did you complete this form on behalf of the Cient? Yes □ No □

Signed by Referrer/ Agency …… Date:……

Print name of Referrer: ……

Please send the completed referral form to: referrals.recovery@liverpoolymca.org.uk

---

FOR OFFICIAL USE ONLY

Is this referral being progressed? Yes □ No □

Feedback from Referral and Assessment Panel: