*Please complete as fully as possible - incomplete or illegible forms may result in a delay in our contact and engagement with the service user.*

For more information, please call the Inroads Surrey team on **0300 303 3141** or contact by secure Egress email to [**Inroads.Surrey@viaorg.uk**](mailto:Inroads.Surrey@viaorg.uk)**.**

## 1. Referrer details

|  |  |  |  |
| --- | --- | --- | --- |
| Name of referrer: |  | Date: |  |
| Job title/role: |  | Phone number: |  |
| Email: |  | Client consent to referral | Yes ¨ No ¨ |

### 2. Service user details

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of birth: |  |
| Gender: |  | NHS number: |  |
| Address: |  | Name of GP: |  |
| Postcode: |  | GP phone number: |  |
| Does the service user give consent for Inroads to contact their GP? | | | Yes ¨ No ¨ |
| Is person known to any homeless/day services? | Yes ¨ No ¨ | Is person sofa surfing or rough sleeping? Any known locations? | Yes ¨ No ¨ |
| Service user’s phone number: |  | Name of service user’s partner: |  |
| Name of next of kin: |  | Permission to contact next of kin: | Yes ¨ No ¨ |
| Next of kin phone number: |  |
| Any children currently living with the service user? | Yes ¨ No ¨ | If yes, please list name and age of each child: |  |

### 3. Service user presentation (please give a brief outline, if no information available please indicate, and complete the risk assessment)

|  |  |
| --- | --- |
| **Alcohol** | |
| 1. Drinking pattern, what, how much, UNIT consumption, how often, time of first drink, any drug use? **Please complete and attach an Audit C to this referral.** |  |
| 1. Does person experience withdrawal symptoms, have seizures? |  |
| 1. Immediate risks and concerns? |  |
| **Physical health** | |
| 1. Diagnosis / admissions / medications: |  |
| 1. Immediate risks and concerns? |  |
| **Mental health** | |
| 1. Diagnosis/episodes/medication: |  |
| 1. Immediate risks and concerns? |  |
| **Offending / forensic / probation** | |
| 1. Please give details: |  |
| 1. Immediate risks and concerns? |  |

**4. In the past 3 months has the service user** (please select all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Tick** | **Frequency/**  **how many** |  | **Tick** | **Frequency/**  **how many** |
| **Been a 999 misuser** |  |  | **Been arrested** |  |  |
| **Had A&E admissions** |  |  | **On police CBO (Criminal Behaviour Order)** |  |  |
| **Been evicted from tenancy** |  |  | **Been referred to Adult Safeguarding as a vulnerable adult e.g. MASH** |  |  |
| **Been NFA (No Fixed Abode)** |  |  | **Subject to SCARF report** |  |  |
| **Been a victim of crime** |  |  | **Been in treatment with i-access** |  |  |
| **Been reported as a missing person** |  |  | **Been with CMHRS** |  |  |

**5. What support would you like from us?**

|  |
| --- |
| Based on your knowledge of the service user, what would you like to see happen? |
|  |
| Is person known to any other services or professionals?If so, please list names and contact details below: |
|  |

**Service User Risk Assessment**

|  |  |  |
| --- | --- | --- |
| Children | Tickif yes | **Notes:** |
| History of, or evidence of, being a risk to children? |  |
| Are any children subject to CP Plan / LAC / CIN? |  |
| Is the service user pregnant? |  |
| **Risk from others** |  | **Notes:** |
| History of, or current domestic abuse |  |
| History of, or evidence of, being exploited by others? |  |
| Risk of suicide |  | **Notes:** |
| Previous suicide attempts? |  |
| Suicidal thoughts? |  |
| Suicide plan? |  |
| Sense of hopelessness? |  |
| Risk of self-neglect |  | **Notes:** |
| History of self-neglect? |  |
| Homeless or inadequate housing? |  |
| Evidence of poor nutrition? |  |
| Evidence of poor hygiene? |  |
| Risk of violence to others |  | **Notes:** |
| Previous violence towards others? |  |
| Talking or planning to harm others? |  |
| Risk to workers? |  |
| Other risks |  | **Notes:** |
| History of, evidence of, or suggestion of self-harm? |  |
| History of, or evidence of, inappropriate sexual behaviour? |  |
| Additionally |  | **Notes:** |
| Are there any factors that may suddenly increase the risk? |  |
| Are there any obvious risks this person poses that are not listed above? |  |
| **Based on answers above does the person require any of the following:**   * Further assessment for risk of suicide * Further assessment of risk of self-neglect * Further assessment of violence to others * Further assessment for risk of sexual assault * Further assessment for risk of significant harm to children * Further assessment for family in need   **Please now complete the Risk Management Plan** | | |

#### Risk Management Plan

#### Please contribute any information you or your organisation will be taking to manage any risk regarding the service user. This information will be used by the Inroads Surrey team to monitor ongoing risk, add to the risk management plan, and inform joint working when required.

|  |
| --- |
| 1. **1. State all the main risks here:** |
|  |
| 1. **2. For EACH of these risks, please state how these risks are or need to be managed?** If nothing in place, can you make recommendations, and your reasons? |
|  |

**Alcohol use disorders identification test (AUDIT)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per month | 2 to 3 times per week | 4 times or more per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but  not in the  last year |  | Yes, during  the last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but  not in the  last year |  | Yes, during  the last year |  |

|  |  |
| --- | --- |
| **Total AUDIT score** |  |

|  |  |
| --- | --- |
| **Name of referrer:** |  |
| **Signature of referrer:** |  |
| **On behalf of:** |  |
| **Date signed:** |  |

Completed referral forms must be sent by secure Egress email to [Inroads.Surrey@viaorg.uk](mailto:Inroads.Surrey@viaorg.uk).