Northern Health and Social Care Trust

Information for completing Referral Form to Addictions Services

Please complete all parts of form as the information will be used to prioritise referrals. Insufficient information prevents triage decision being made.

Physical health concerns
Patients requiring immediate assessment of serious physical health problems should be referred to medical/emergency services.

Mental health concerns
Patients who are experiencing significant primary mental health difficulties co-existing with substance use should be referred to Crisis Resolution Teams or Sector Mental Health Teams, depending on the assessed level of risk.

Recommended investigations in Primary Care

Please forward copies of all investigations undertaken in the last 8 weeks. If appropriate, please check FBP, LFT's, U&E and arrange a urine drug screen.

If appropriate please offer testing for Hepatitis B, Hepatitis C, HIV and arrange for a course of Hepatitis B immunisation to be given to all intravenous drug users or anyone who has been exposed to blood borne viruses through other routes. (This includes individuals who are snorting Cocaine).

N.B. Please attach a list of all current prescription medication and any other relevant information.

Please send referrals to enquiries.cas@northerntrust.hscni.net.

Please note: The referral form is used by other Healthcare Professionals and the Community and Voluntary sector. It is acknowledged that Community Pharmacists will not have access to all of the information requested on the form. Required information is:

- Patient details including their most recent contact details
- Referrer details
- Substances of misuse, including level and duration of use
- Any criteria that would flag an urgent referral if known

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Referral Form to Addictions Services

Date of Referral:

Client/Patient Details

Name				
DoB			**Age**	
H&C No.			**Sex**	**Male / Female**
Address				
			Postcode	
Contact No.	**Tel**		**Mobile**	

Referrer Details

Surgery/Service				
Name				
Designation				
Address				
			Postcode	
Contact No.	**Tel**		**Fax**	

Medical Details

Investigation	**Test results *(tick)***		**Test not completed**	**Date test completed**
	enclosed	**to follow**		
FBP				/ /
LFT				/ /
U&E				/ /
Urine drug screen				/ /
Hepatitis B				/ /
Hepatitis C				/ /
HIV				/ /
Vaccination	**Date**	**Date**	**Date**	**NA *(tick)***
Hepatitis B	/ /	/ /	/ /	
List of current medication attached **(Please Circle)**				**Yes / No**

Reason for referral (why now?):
Details of previous treatment with Addictions Services/other agencies for substance dependence:
Current forensic/legal issues: **YES / NO** ***Please Specify:***
Any supportive relationships with a partner and/or family **YES / NO** ***Please specify:***

Substance Use Details

Substance	***Tick*** ✓	***Weekly intake (incl. unit of measurement***	***Frequency of use (daily/ weekly/binge)***	***Length of problem use (mths/yrs)***	***Route of use (IV/oral/smoking/ inhaling)***
Alcohol		(units)			
Heroin					
Codeine Products					
Dihydrocodeine					
Methadone					
Buprenorphine					
Cannabis					
Benzodiazepine *Prescribed*					
Benzodiazepine *Non-prescribed*					
Amphetamines					
Cocaine/Crack					
Ecstasy					
Solvents					
Other (specify):					
Alcohol use					
Drinking to alleviate withdrawal symptoms (PLEASE CIRCLE):					**YES / NO**
History of seizures observed and medically verified (PLEASE CIRCLE):					**YES / NO**
History of DT's observed and medically verified (PLEASE CIRCLE):					**YES / NO**

Risk factors suggesting priority for treatment (Please tick all that apply)

- ☐ Pregnant or partner is pregnant
- ☐ Risk to children in the family home
- ☐ Domestic violence
- ☐ History of violence/harm to others
- ☐ Intravenous drug use
- ☐ Significant physical health problems (e.g. liver disease)
- ☐ Significant mental health problems (e.g. severe mental disorder).
- ☐ High-risk polysubstance misuse (concern of toxicity/chemical interactions)
- ☐ Evidence of self-harm/self-neglect
- ☐ Homeless or no fixed abode
- ☐ Risk of harm from others
- ☐ Other, please specify: _____

If any of the above risk factors have been identified please elaborate and include details of how risk is being managed e.g. UNOCINI completed, Social Services involvement:

Please tick to confirm patient has provided consent for referral to the Community Addiction Service ☐

The completed form should be sent to enquiries.cas@northerntrust.hscni.net.