

**REFERRAL DOCUMENT**

**If you need any advice or guidance completing this document, please contact us via one of the methods below:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Office** | **Address** |  |  |
| **North** |  |  |  |
| CarlislePenrith | 1st Floor, Stocklund House, Carlisle, CA3 8SYEden Rural Foyer, Old London Road, Penrith, CA11 8ET |  |  |
| **West** |  |  |  |
| Workington | 6 Finkle Street, Workington, CA14 2AY |  |  |
| Whitehaven | 21b Lowther Street, Whitehaven, CA28 7DG |  |  |
| **South** |  |  |  |
| Barrow | 92-96 Duke Street, Barrow, LA14 1RD |  |  |
| Kendal | White Horse Yard, 39 Stricklandgate, Kendal, LA9 4LT |  |  |

**Telephone :** 01900 512300, select either option 1 for Carlisle / Eden, option 2 for W&W and option 3 for B&K

**Email**: Referrals@recoverystepscumbria.org.uk

*Please send forms to* ***referrals@recoverystepscumbria.org.uk***

*\* Indicates a mandatory field*

|  |  |  |
| --- | --- | --- |
| **Referral Date:** |  |  |

**Personal Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name\*** |  |  | **Date of Birth\*** |  |
| **Surname\*** |  | **Gender (at birth) \*** | Male [ ]  |
|  |  |  |  | Female [ ]  |
| **NHS Number** |  |  |  | Prefer not to say [ ]  |
|  | **Do you identify as the gender you were born?** | Yes [ ]  |
|  |  | No [ ]  |
|  |  | Prefer not to say [ ]  |
|  |  |  |

**Address & Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Address 1\*** |  | **Telephone Number\*** |  |
| **Address 2** |  | **Mobile Number\*** |  |
| **Town/City** |  | **Email\*** |  |
| **County** |  | **No Fixed Abode** |[ ]
| **Postcode\*** |  |

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name\*** |  | **Referrer contact details\*** |  |
| **Referral Source\*** |  | **Referrer Email\*** |  |

**Drug & Alcohol Use**

|  |  |  |
| --- | --- | --- |
| **Substance use (current frequency and amount)\****Give details of:** *any current/recent/past drug or alcohol use*
* *any previous drug/ alcohol treatment received*
 |  |   |
| **Date Last Used Substance** |  |  |
| **Reason for Referral / What is the Goal from Treatment?** |  |  |

**About You**

|  |  |
| --- | --- |
| **Physical/Mental Health\****Give details of:** *physical health issues*
* *mental health issues*
* *prescribed medications*

*involvement with mental services* |  |
| **Communication/information needs\*** *Give details of any information/communication needs such as interpreter required, large print letters, BSL, induction loop etc* |  |
| **Barriers to Accessing the Service\*** *Physical or mental health needs which could impact your ability to attend*  |  |
| **Support Network** *Details of any other professionals you are currently being supported by e.g. carer, mental health services, social care etc. Please provide name(s) and contact details of all those supporting you.*  |  |
| **Do you give us consent to contact your Support Network if needed?** |  |
| **Employment status \***  |  |
| **Area of Employment**  |  |
| **Hours of Work** *This is so we can try to book appointments around your working hours (if needed)* |  |
| **Are you pregnant / partner of someone who is pregnant?\*** *Please provide details.* |  |
| **Are you a carer for someone else?** *Please provide details.* |  |
| **Do you have regular contact with U18s?** *For example, either those who live with you or may visit or you may visit. Please provide details.* |  |
| **How safe do you feel today?** |  |
| **If you answered yes to any of the above questions, please provide any further details or anything else you wish to share** |

*Thank you! We will be in touch with you within 24-72 hours to explain what happens next.*