 **Date of referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
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| **Programme referred to:** | **Please tick-x** |
| **Men’s Drug Free Residential-Ashford** |  |
| **Women’s Drug Free Residential-Brittas Bay** |  |
| **Arklow Day Services** |  |
| **Family Services** |  |
| **OTHER** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name** | **Address** | **Contact Number** | |
|  |  |  | |
| **Gender Male/ Female:** | **Ethnic Origin:** | **Family Status, Include dependent children** | |
| **D.O.B:** | **Living with (circle one):**  **Alone, parents /family, friends, partner, partner & children, alone with children, foster care other, Not known** | **Living where (circle one):**  **stable accommodation, institution, homeless, unstable accommodation, other** | |
| **P.P.S No:** | **Source of Referral (circle one): Self, Family, Friends, Other drug treatment centre GP ,*Acute Hospital Service (excluding A&E), Social / Community Service, Court/Probation/Police, Outreach Worker Harm Reduction programme ,School,Prison,Employer ,Mental Health Liaison Nurse at A&E Accident & Emergency, other Mental health service (including psychiatrist) , Not known*** | |  |

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| **Reason for Referral** |
|  |
| **Next of Kin** |
| **Name**  **Address**  **Phone**  **Is this person aware of drug use / contact with this service? Y N** |

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| --- |
| **Current Drug Use: (Please give details)** |
| **Type of contact with this programme circle one**  **First treatment One or more treatment periods Not known**  **Number of times started treatment in this programme this year (Jan to Dec) ……………..**  **Ever previously treated for problem drug use? Circle one**  **Never treated Previously treated Not known Not applicable**  **If previously treated, state which drug …………………….**  **If previously received opioid replacement treatment, please specify age first received opioid substitution treatment ……….. Not known**  **Specify first drug used (excluding alcohol) ………………age at first …………………….**  **Drug type**  **Please rate order of preference / regularity in the brackets e.g. 1, 2, 3 ect..**  **Age at first use How often How Often Amount used Route of transmission.**  **Heroin**  **( \_\_\_)**  **Cocaine**  **( \_\_\_)**  **Benzodiazepine**  **( \_\_\_)**  **Amphetamines**  **(Crystal Meth)**  **( \_\_\_)**  **Ecstasy**  **( \_\_\_)**  **Cannabis**  **( \_\_\_)**  **Alcohol**  **( \_\_\_)**  **Methadone**  **( \_\_\_)**  **Tobacco**  **( \_\_\_)**  **Codeine**  **( \_\_\_)**  **Other**  **( \_\_\_)** |
| **Current Alcohol Use: (Please give details)** |
| **Specify main type of alcohol consumed:**  **Beer ,spirits ,wine, fortified wine, cider, alcopops:**  **Other……………………………………………………………………..**  **How many drinks were consumed over a typical drinking session over the past month……………. If none, put 0**  **Number of days alcohol was consumed over the past month……………………………………………….. If none, put 0**  **Please categorise the extent of the drinking problem (as per audit tool circle one)**  **hazardous drinker harmful drinker dependent drinker**  **Ever previously treated for problem alcohol use? Circle one**  **Never treated Previously treated Not known Not applicable** |
| **Previous Detox & Rehabilitation Programmes: (Please give details)** |
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| **Is a detox Needed? If so individual will need to be referred to detox centre** |
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| **Why do you want treatment now?** |
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| **Physical Health Needs (Please detail)** | **Mental Health Needs (Please detail)** | **Medication Prescribed** | **Dosage** |
|  |  |  |  |
| **GP/CLINIC** | **ADDRESS** | **TELEPHONE NUMBER** |  |
|  |  |  |  |

**Legal Issues**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Charges/orders. (Please Detail)** | **Next Court Date(s)** | **Probation Officer** | **Probation Involvement** | **Is urinalysis & court report requested** |
|  |  |  |  |  |
| **Current Offence(s)** | **Outstanding Charge(s)** | **Previous Convictions** | **Prison Release Date if applicable** | **Involvement in Feuds/Health & Safety concerns** |
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| --- | --- | --- |
| **Family Support/Concerned Persons/Significant Others:** | **Relationship to you** | **Phone Number** |
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**FAMILY SUPPORT REFERRAL DETAILS, *(for family members-parents, spouses, partners, sibling or children of STUDENTS engaging with Tiglin Services).***

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| **PROGRAMME** | **PLEASE TICK** | **STUDENT NAME** |
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| **FAMILY MEMBER NAME** | **PHONE:** | **RELATIONSHIP TO STUDENT:** | **ADDRESS:** | **PERMISSION TO CONTACT, PLEASE TICK** |
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For Further Information please contact Marilyn at Tiglin Family Support 085)8875774

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| **Referral Agent Name:** | **Keyworker/Probation Officer/Contact Person** | **Address** | **Telephone:** | **Length of contact with client** |
|  |  |  |  |  |

Services currently involved or which have been involved in service users care plan to date: ­­­­­­­-­

­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What supports are needed for service user to progress

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What are service users goals Short term/Long term

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff will make contact with you within 4 days of receipt of this referral.

Referral Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you. Please return completed forms to: Tiglin Challenge, Ashford, Co. Wicklow or by email to [admin@tiglin.ie](mailto:admin@tiglin.ie); Fax Number: 0404)40020

*Men’s Residential: 0404)49683; Women’s Residential 0404)47552; Tiglin Day Service: 0402)33898 & 085)8695964; Family Support 0858875774*