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

|  |  |
| --- | --- |
| **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***  |  |

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

|  |
| --- |
| **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)** |
|  |

|  |
| --- |
| **Is a detox Needed? If so individual will need to be referred to detox centre** |
|  |

|  |
| --- |
| **Why do you want treatment now?** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Family Support/Concerned Persons/Significant Others:** | **Relationship to you** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FAMILY SUPPORT REFERRAL DETAILS, *(for family members-parents, spouses, partners, sibling or children of STUDENTS engaging with Tiglin Services).***

|  |  |  |
| --- | --- | --- |
| **PROGRAMME** | **PLEASE TICK** | **STUDENT NAME** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FAMILY MEMBER NAME** | **PHONE:** | **RELATIONSHIP TO STUDENT:** | **ADDRESS:** | **PERMISSION TO CONTACT, PLEASE TICK** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

For Further Information please contact Marilyn at Tiglin Family Support 085)8875774

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

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

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; Fax Number: 0404)40020

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