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| --- |
| **REFERRER DETAILS (if a 3rd party)** |
|  **Your name** |  |  **Agency name** |  |
|  **Telephone no.** |  |  **Email** |  |
|  **Address** |  |
| **CLIENT DETAILS** |
|  **First name** | Click here to enter text. |  **Last name** | Click here to enter text. |
|  **Date of birth** | Click here to enter a date. |  **Client stated sex**  **(as per birth or gender re-** **assignment certificate)** | [ ]  Male [ ]  Female |
| **Address** | Click here to enter text. | **Self-identified gender** | Click here to enter text. |
|  **Postcode** |  Click here to enter text. |  **Can we write to this address?** | [ ] Yes [ ] No |
| **Mobile number** | Click here to enter text. | **Permission to text?** [ ] Yes [ ] No **Permission to leave a voicemail?**  [ ] Yes [ ] No |
| **Landline** | Click here to enter text. | **Permission to leave a message?** [ ]  Yes[ ] No |
| **Email address**  | [ ] No [ ] Yes Click here to enter text. |
| **Contact preference** | Click here to enter text. |
| **Interpreter needed?** | [ ] No [ ] Yes Language: Click here to enter text. |
| **GP details - name & surgery** (if known) | Click here to enter text.Tick if **not** registered with a GP [ ]  |
| **Details of any disabilities or access needs** | Click here to enter text. |
| **How did the client hear about us?** | [ ] Online [ ] Leaflet/poster [ ] A professional [ ] Family/friend [ ] Other Click here to enter text. |
| **Reason for referral/client’s view** | Click here to enter text. |
| **SUBSTANCE USE** |
|  **Substance**  | **Route -Smoke/****Inject /sniff etc** | **Frequency**  | **How much?** | **Age first used** (if known) |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **If alcohol use in past 12 months complete Alcohol Audit** | **Score** | Click here to enter text. |
| **RISK & SAFEGUARDING** |
| **Are there any significant risks we should be aware of?** |
| **Substance Use** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Physical/Mental health** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Risk of harm** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Suicidal intent** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Children’s safeguarding/Pregnancy** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Other** | [ ]  No  | [ ]  Yes Click here to enter text. |
| **Any further information** |
| Click here to enter text. |
| **Please ensure ALL the information is completed**Fields marked with must be uploaded to the record as they are reportable to NDTMSFor external professionals use only: Please send the completed form to:**Turningpoint.lrpspoc@nhs.net** |