|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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?**  YesNo | | | | | |
| **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 NDTMS  For external professionals use only:  Please send the completed form to:  **Turningpoint.lrpspoc@nhs.net** | | | | | | | | | | | | | |