RAPID ACCESS TO DRUG AND ALCOHOL RECOVERY (RADAR)

Referral Form

PLEASE ENSURE THAT CLIENT IS AWARE THAT INFORMATION WILL BE SHARED BETWEEN SERVICES

NOTE: For family/carer support, please use family referral form

Patient Details

Name: _____

D.O.B: _____

CHI. No: _____

Address: _____

_____

Tel. No: _____

Mobile. No: _____

GP Practice

GP Name: _____

Address: _____

_____

_____

Tel. No: _____

Referrer Details

Name: _____

Job Title: _____

Service/Organisation: _____

_____

Address: _____

_____

_____

Tel. No: _____

Date of Referral _____

Name of worker taking referral details

_____

Is GP aware of referral?

☐ Yes ☐ No

(For all Detox referrals: Please advise GP of referral)

Is patient aware of this referral and consented to referral?
YES ☐ / NO ☐

Reason for Referral

☐ Alcohol ☐ Drug

Current Substance(s) - _____

Average daily intake - _____

How is substance(s) being taken?

☐ Oral ☐ Smoking ☐ Injecting

RECOVERY

What addiction support does the person wish to assist with their recovery?

_____

_____

What is the person's recovery aims/aspirations and within what timescales?

_____

_____

Type of Treatment

☐ Detoxification	☐ Relapse Management	☐ Substitute Medication
☐ Occupational Therapy	☐ Counselling	☐ Mental Health
☐ Recovery group work	☐ Ward 5 day attendance	☐ Ward 5 Residential

☐ Psychosocial interventions ☐ Any other intervention e.g ADVOCACY

Any current or previous mental health problems? (If yes, please give details): _____ _____	YES ☐ / NO ☐
Any history of aggression or violence? (If yes, please give details): For example is it unsafe for lone worker to visit at home. _____ _____	YES ☐ / NO ☐
Any additional risk, If yes please give details _____ _____	YES ☐ / NO ☐
Is client or partner pregnant	YES ☐ / NO ☐
Living with own/partner's children	YES ☐ / NO ☐
Any prescribed medication relevant to this referral (include dose)? (if yes, please give details) _____ _____	YES ☐ / NO ☐

Any additional support needs e.g. – Language interpreter required, vision impairment, hearing impairment, sign language interpreter required:

_____
_____

Any further relevant information – (e.g. any involvement with other services). Please detail

Referrals can be emailed via secure email account:

aa.radar@aapct.scot.nhs.uk

Referral forms can be posted to:

Rapid Access to Drug and Alcohol Recovery Service
North West Kilmarnock Area Centre
Western Road
Kilmarnock
KA3 1NQ