Somerset Drug & Alcohol Service

Referral Form

Name of person being referred:

Date of birth: DD / MM / YYYY

Gender:

Telephone No:

Address:

Postcode:

Mobile:

Email:

Preferred contact method: Post: ☐ Email: ☐ Phone: ☐ Mobile: ☐ Text: ☐

Consent given to a home visit? Yes ☐ No ☐

Young Person's Screening or Assessment tool attached? Yes ☐ No ☐

Completed AUDIT attached? Yes ☐ No ☐

Summarise the **drug and / or alcohol** issues:

Summarise **risks**:

Risk assessment attached? Yes ☐ No ☐

Is there any **Children's Social Care** involvement? Yes ☐ No ☐ (if yes please expand below)

Is there a **housing** issue? Yes ☐ No ☐ (if yes please expand below)

Any other relevant information:

Referrer's contact details:

Name: Organisation:

Phone: Date of referral:

Send completed referral form to SDAS Point of Contact:

Email: somerset.das@cgl.org.uk Fax: 01823 288238 Phone: 0300 303 8788