|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:**  **Client Phone Number:**  **Client Email/Referral Email:** | |  | | | | | | | | | | |
| **DOB:** | | **Age:** | | | | | | | | | | |
| **Regrettably, our recovery project cannot accept individuals with sex offenses or arson-related convictions.**  **Thank you for your interest in our project.** | | | | | | | | | | | | |
| **Gender:**  (Please Tick) | | **Male** | | | |
| **Female** | | | |
| **Home Address:** | | | | | |
| **Postcode:** | | | | | |
| **Which service do you require?**  (Tick which apply) | | | | | | | | | | | | |
| **Addiction Recovery** (Alcohol and other drugs) | | | | | |  |
| **Mental Health Recovery** | | | | | |  |
| **Homeless Housing** | | | | | |  |
| **Prison Number:**(If Applicable) | | | | | **NI Number:** | | | | |
| **Date of Referral to ABT:** | | | | **/ /** | | | | | **Part of the call back**  **Support Worker Check List**  **(Office Use Only)** | | |
| **Referred By:**  **(Please Tick)** | | | | **Primary Addiction:**  **(Please Tick)** | | | | |
| **Offender Management** | | |  | **Opiate** | | | |  | Sex offenses – Arson? | |  |
| **Drug/Alcohol Services** | | |  | **Non-opiate** | | | |  | Psychiatrist - MH Team? | |  |
| **Non-Drug/Alcohol Services** | | |  | **Non-opiate and Alcohol** | | | |  | IOM - Probation – TAG? | |  |
| **NHS/Health** | | |  | **Alcohol Only** | | | |  | Script - DEPO - Meds? | |  |
| **Self-Referral** | | |  | **Opiate and Alcohol** | | | |  | Home area - UK residency? | |  |
| **Returning Client** | | |  |  | | | |  | [Benefits Entitlement](https://www.gov.uk/browse/benefits/manage-your-benefit)? | |  |
| **Details of Referral**  (e.g., NHS) |  | | | | | | | | | | | |
| **General Information and support needs**  (e.g., Working with CMHT)  **Including Medical Conditions, Mental Health and any possible triggers** |  | | | | | | | | | | | |

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| --- | --- | --- | --- |
| **Medication Information:**  **(e.g. Methadone)**  Include any over-the-counter medication | | | |
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| **Past History of Addictions:**  (I.e. date of onset, diagnosis, treatments, admissions) | | | |
|  | | | |
| **Criminal Offending History:** | | | |
| **Offence:** | **Date:** | | **Length of Sentence:** |
|  |  | |  |
| **Do you receive any benefits?**  (Including PIP and Housing) | | | |
| **Name of Benefits:** | | **Details:** | |
| **Additional Information:** | | | |
|  | | | |