**Details of person being referred:**

Phone number 0300 123 1560

**Email:** Theforwardtrust.medway@nhs.net

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  | | | | Referral Date: |  |
| Date of birth: |  | Age: | |  | NHS number: |  |
| Address: |  | | | | Postcode: |  |
| Telephone number: |  | | Mobile number: | |  | |
| Email: |  | | | | | |
| How does the patient/client wish to be contacted?  Landline Mobile phone Letter Email Other | | | | | | |
| What is the patient/client availability for appointments? | | | | | | |

|  |
| --- |
| **Details of substance misuse:** E.g. heroin (injected), crack (smoked), alcohol (oral) |
|  |
| **Please attach GP summary** |
| **Known risk to others (if any):** Eg. No lone working, no female workers |
| **Other important relevant health information** |

**Details of person/organisation making referral:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Role: |  |
| Organisation: |  | | |
| Telephone no: |  | | |
| Email: |  | | |

**Criminal Justice Referral requirement(s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Order Type: | ATR DRR LICENCE SSO CO | | |
| Length of engagement required: | From: To: | | |
| CJLDS |  |  | |
| Offences: |  | | |
| Allocated officer: |  | | |
| Is drug treatment a **condition** of their order/licence? | | | Yes No |

|  |
| --- |
| Does the person know you are making a referral? o Yes o No  Do they want to be referred to Southend on Sea Service and consent to share information? o Yes o No  Would you like feedback on the outcome of this referral? o Yes o No |