Referral Form

Client Name: **Client Phone Number:** **Client Email/Referral Email:**	
DOB:	**Age:**

Gender: (Please Tick)	**Male**	
	Female	
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:	**/ /**

Referred By: **(Please Tick)**		**Primary Addiction:** **(Please Tick)**	
Offender Management		**Opiate**	
Drug/Alcohol Services		**Non-opiate**	
Non-Drug/Alcohol Services		**Non-opiate and Alcohol**	
NHS/Health		**Alcohol Only**	
Self-Referral		**Opiate and Alcohol**	
Returning Client			

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	

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: