North Yorkshire Horizons Referral and Triage Form

1. BASIC INFORMATION	
First Name:	Surname:
Address: Postcode: Homeless: Y/N	Date of Birth: Age: Gender (M/F): Ethnicity:
Housing Type (social/Private Rented/Supported etc...)**:**	
Tel:	Mobile:
Email Address (if applicable):	
Can we contact you by? Mobile Y/N Text Y/N Landline Y/N Email Y/N Letter Y/N Home Visit Y/N	
2. GP- being registered with a GP is important to ensure comprehensive treatment	
Name:	Tel:
Address:	Postcode:

3. REFERRER'S DETAILS **Self-Referral ☐**

Organisation: Referrers Name:
Address:
Tel:
Relationship: GP/Family member/Consultant/other (please identify)
Does the person being referred know you are contacting us today? Y/N

4. CURRENT SUBSTANCE USE ***Please list all substances used, whether illicit or prescribed, include alcohol and cigarettes rank order route & frequency***

1. **3.** **5.**
2. **4.** **6.**
Smoker? **Yes ☐** No ☐ Quantity per Day: 1-10 ☐ 11-20 ☐ 20-30 ☐ 30+ ☐
Referred to smoking cessation Yes ☐ No ☐
AUDIT (Alcohol) SCORE:
Are you prescribed any medication by GP? Is yes, please give details:

How are you currently funding your substance misuse:

Have you ever received previous treatment for substance misuse? If yes, please give details

What is your treatment Goal: ie) abstinence, reduction etc

What do you want to achieve from working with NYH? (Expectations etc)

What do you think your current risks are related to your substance use (IV, poly, DVT, domestic violence etc)?

Informed of Information about NYH service, what's on offer and local mutual aid groups: Y/ N

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5. HEALTH NEEDS (Physical & Mental)

Do you consider yourself to have a Physical health need? Y/N

Have you had a sexual health screening? Yes ☐ No ☐ If no, referral made? Yes ☐ No ☐

Do you have a diagnosis from a doctor/consultant? Y/N

If Yes, what is your diagnosis?

Do you consider yourself to have a mental health need? Y/N

If yes do you have a diagnosis from a doctor/consultant? Y/N If yes, what is your diagnosis:

Are you under the care of a Specialist or GP for either of above? If Yes, please give details: Name, Contact information etc.

Do you have difficulty getting to appointments or are you registered as disable? Y/N

6. SPECIFIC CONCERNS/RISKS/INFORMATION

Pregnant or chance may be? Y/N
If yes who is your named Midwife?

Have you had any involvement with Criminal Justice ie:
Are you here as a result of a court order? Y/N
Have you a recently (**last 12 months**) been released from prison? Y/N **Date:**
Are you involved in the Criminal Justice System? (Probation/Police) Y/N
Have you been asked to attend by the Police as an arrest referral? Y/N
Are you accessing Women's services? (If yes, which?) Y/N

If yes to any above, please give specific details and contact details of professionals you are working with:
Detail of Involvement (DRR/ATR/Tagged/etc...):

Name: Organisation: Contact number:

Are you able to read and write? Y/N

Do you have children or contact with children? Y/N
If yes please identify names and DOB of the children:

If yes, do you have contact with social care? Y/N
If yes please give social workers contact details:
Name: Contact Number:

Question for professional Referrer only: Does this person pose a risk to staff/others? If yes, please provide details and forward a copy of risk assessment to SPOC FAX 01723 353840 Yes / No
Details:

Risk assessment received: Y/ N

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7. Family/Carer Support

Does anyone else know you are contacting us today? If yes who?

Do you have family we can offer support to? If yes please give us their contact details:

8. ANY OTHER RELEVANT INFORMATION

Have you received a day's pay from any of the armed forces? Y/N
Are you a Yorkshire Coast Homes Tennant? Y/N
(If Yes and audit score 20 or below offer to refer to Community substance Misuse Worker – Scarborough/Whitby only)

9. CONSENT STATEMENT (to be signed by service user where possible):

I understand that the information given on this form will be passed to the above agency for a more detailed assessment and to discuss the best options with me. I am aware that I have agreed to this referral being made and that anonymous details may be used for evaluation and monitoring purposes. I understand that the referring agency may be informed of my attendance at the appointment.
I understand that the agency I am being referred to have offered me/will offer me an appointment by post/telephone and that another assessment will be carried out to best meet my needs.

Signature of person taking referral…… Date…….

Signature of service user ……. Date…….

If Triage completed by telephone has client has given verbal consent ☐

OFFICE USE ONLY: Referral passed to:

A&E Y/N EIP Y/N R&M Y/N Inappropriate referral as does not meet threshold **Y/N**

Referral passed to: Harrogate ☐ Skipton ☐ Selby ☐ Northallerton ☐ Scarborough ☐

Additional information or summary if required: