CDAS Referral Form - For Professionals

This is a referral form for Stoke-on-Trent's Community Drug and Alcohol Service. Please provide as much information as possible in the questions below, gaining consent from the person you're supporting, prior to submitting the referred information.

If you need to speak to a member of our team prior to making the referral, please contact us on **01782 283 113.**

Please send your completed form to referrals@sotcdas.org.uk

Details of the person being referred to our service	
First Name(s):	Surname:
Date of birth:	Ethnicity:
Address:	Telephone contact:
	Can we contact via this number: Yes / No
Postcode:	Is this a hostel or Concrete/Saltbox property? Yes/No
Can we send letters to this address: Yes / No	Is this client at current risk of eviction (e.g.- live warning/written notice/rent arrears): Yes/No
GP surgery:	
Accessibility need for appointment (disability/employed/translator):	

Has the client consented to the referral: Yes / No
DOES THIS CLIENT HAVE AN OPIATE RE-ENGAGEMENT PLAN (Self Referrals Only) OFFICE USE ONLY

Please state any known substance misuse:

Please list:

- Substance(s)
- Type(s)
- Amount(s)
- Frequency (daily/weekly)
- Route of use (e.g., injection, smoking, oral)

Please state any known risks, including:

- Safeguarding concerns (e.g., children's details)
- Mental health issues (e.g., self-harm, overdose)
- Risks to staff
- Risks to others

Are there any other agencies working with the client? Please provide full names and contact details. Next appointment/s -

Referer details	
Full name:	**Service/Organisation:**
Contact number(s):	
Email address:	
Do you require feedback: Yes / No	

Please send your completed form to referrals@sotcdas.org.uk