DROP
Acceptance • Support • Progression

45 Upper George's Street Dun Laoghaire, Co. Dublin
phone 01 2803187 fax 01 2301716
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SERVICE USER REFERRAL FORM

DETAILS OF THE PERSON BEING REFERRED	DETAILS OF REFERRER
Forename: Surname: Address: Date of birth: Male ☐ Female ☐ Telephone number: Mobile Number: Is service user aware of the referral? Y ☐ N ☐	Referrers Name: Job title: Name of referring organisation: Address: Telephone number: Email address: Wish to be kept informed? Y ☐ N ☐
CONSENT Is it ok to send mail/text/email? Y ☐ N ☐ Is it ok to call/leave message? Y ☐ N ☐	GP Name GP Address GP Telephone:

WHAT SERVICE/SUPPORT IS REQUIRED?	PRESENTING PROBLEM (PLEASE TICK):
☐ Brief Intervention/Harm Reduction ☐ Community Detoxification Support ☐ One to one support work ☐ Assistance to access detox/residential facility ☐ Pre Entry Programme ☐ Stabilisation programme ☐ Drug Free Programme	☐ Alcohol Use ☐ Drug Use ☐ Alcohol & Drug Use ☐ Drug use and gambling ☐ Alcohol use and gambling
CURRENT DRUG USE WITH DATE OF MOST RECENT SUBSTANCE MISUSE:	**CURRENT PRESCRIPTION MEDICATION AND PRESCRIBER:**

AREAS OF RISK

☐ Responsible for children	☐ Homeless/at risk?
☐ Pregnancy	☐ Recently released from prison
☐ Domestic violence	☐ Due to be released from prison
☐ Violence/aggression	☐ Challenging behaviour
☐ Currently IV drug use	☐ Self harm
☐ Sharing equipment	☐ Other _____

WAS A RISK ASSESSMENT COMPLETED?

Yes ☐ No ☐ Not known ☐ IF YES PLEASE SPECIFY AND/OR PLEASE PROVIDE ANY RELEVANT REPORTS

Supported by: Department of Social Protection, Health Service Executive, Dun Laoghaire Rathdown Drug & Alcohol Task Force, Dublin and Dun Laoghaire Education and Training Board and the local community of Dun Laoghaire Rathdown
Company No: 298396 | Charity No: CHY17399

ANY RELEVANT DIAGNOSIS PHYSICAL/MENTAL HEALTH PROBLEMS (DISABLED, POOR MOBILITY, PSYCHOSIS, OTHER ACCESSIBILITY ISSUES ETC.)

LEGAL ISSUES IF KNOWN

☐ None
☐ On Probation
☐ On Probation with condition to attend
☐ Cases Pending
Court dates & charges
☐ Awaiting Sentence
☐ Other

PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION, INCLUDING:

- Brief history of the problem
- Involvement with any other services
- Housing situation
- Is the service user ready to attend our services

FAMILY INVOLVEMENT/CONCERNED PERSONS

CONCERNED PERSON'S NAME	RELATIONSHIP TYPE	PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR SERVICE	
DATE OF REFERRAL	

COMPLETED REFERRAL FORMS SHOULD BE RETURNED BY POST OR EMAIL, MARKED PRIVATE & CONFIDENTIAL TO:

ANTHEA CARRY | DUN LAOGHAIRE RATHDOWN OUTREACH PROJECT | 45 UPPER GEORGES STREET, DUN LAOGHAIRE, CO. DUBLIN | MANAGER@DROP.IE

OFFICE USE ONLY (to be completed by member of intake team)

Service User Name:	DOB:	☐ Referral entered into eCASS **Client Reference No:**

Date referral Received:	Initial Contact made with service user Yes ☐ No ☐ Date of motivation assessment: _____ Date of Initial Assessment: _____
☐ New Referral ☐ Re-referral within 6 months ☐ Re-referral outside 6 months	☐ Accepted ☐ Not suitable, Reason:
☐ Allocated to: ☐ Date Allocated:	☐ Transferred Date of Transfer: _____ ☐ Service transferred to:

WAITING LIST Date placed on waiting list _____ Number on Waiting list _____ Most suitable day/time _____ _____	Unavailable for assessment from _____ To _____ (dates) Reason for unavailability: ☐ Legal ☐ Medical ☐ Social

☐ Referral form uploaded to eCASS ☐ Initial Assessment details input to eCASS

☐ Privacy Statement Signed & uploaded to eCASS

ADDITIONAL NOTES