



REFERRAL FORM

To be completed by all referrers prior to assessment and faxed to 01293 825400
(N.B. this is a telephone/fax line, please ring and let us know prior to sending fax)

Treatment Centre: _____ Date Admitted: _____

Expected date of Discharge: _____

Client Name: _____ D.O.B.: ____ / ____ / ____

Drug(s) of Choice: _____

Reasons for Referral: (please indicate specific areas of need)

1. _____
2. _____
3. _____

Psychiatric History / Dual Diagnosis: _____

Current Medication if any: _____

Name of Psychiatrist: _____ Tel No: _____

Any other Medical Issues: (e.g. disabilities/allergies etc) _____

Are there any concerns about Risk Behaviours: (e.g. Self Harm, Aggressive Behaviour towards others?)

Current Legal Issues: (e.g. drink driving offences, child custody etc): _____

If Local Authority Funding has been applied for, please state current position and contact details including telephone no:

We appreciate your co-operation in completing this form as thoroughly as possible.

I give permission for the above information to be disclosed to Prinsted.