For any queries or assistance completing this form, telephone **01622 812603**

and discuss with **Sarah Turner** or **Samantha Hopper**

**Referral guidance**

Service users **must sign a handwritten signature** theconsent to admission and to information-sharing at the end of this form. Please discuss with us if obtaining consent is difficult.

* Referrals must be emailed to [admissions@kenwardtrust.org.uk](mailto:admissions@kenwardtrust.org.uk) **PLEASE DO NOT POST**.
* Referrals will normally be acknowledged within 1 working day: please contact us on 01622 812 603 if no confirmation has been received.

**Key contacts**

Mark Holmes CQC Registered Manager: [mark.holmes@kenwardtrust.org.uk](mailto:mark.holmes@kenwardtrust.org.uk)

Dr Annie McCloud, Consultant Addictions Psychiatrist: [annie.mcloud@kenwardtrust.org.uk](mailto:annie.mcloud@kenwardtrust.org.uk)

**Referral checklist**

|  |  |
| --- | --- |
| **Form completed** |  |
| **Client consent** |  |
| **GP SCR**  Summary record including past medical history and medication list |  |
| **Relevant blood and urine drug tests**  If it’s not possible to obtain up to date bloods advise why e.g. no IV access due to drug use please give details below: |  |
|  | |
| **Risk assessment** |  |
| **Other reports**  e.g. probation, social work, psychiatric, medical reports, please list below: |  |
|  | |

**Section 1: Client details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Alias** |  |
| **Pronouns** |  | **Gender / prefers not to say** |  |
| **Date of birth** |  | **Age** |  |
| **Contact Number** |  | **Email** |  |
| **N.I. Number** |  | **NHS Number** |  |
| **Religion/ Spirituality** |  | **Nationality** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Married** |  | **Single** |  | **Separated** |  | **Widowed** |  | **Divorced** |  | **Living with a Partner** |  | **Civil Partnership** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current address**  Including post code |  | | |
| **Lives alone**  Delete as appropriate | **YES / NO** | **Status**  Delete as appropriate | Temporary address  Hostel  NFA: Borough connection  Own tenancy  Lives with family/friend on a permanent basis |

|  |
| --- |
| **Employment status / Past employment** (give details below) |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Children or Elder responsibility** (give details below) | | | | |
|  | | | | |
| **Does the service user have parental responsibility?**  Delete as appropriate | **YES / NO** | **Are the children or the parent resident with the service user?**  Delete as appropriate | **YES / NO** | **NB**  Children under the age of 16? If YES, please also complete Section 14 |

**Section 1: Client details (continued)**

|  |
| --- |
| **Current residence or location of patient if different from usual address e.g. hospital, prison** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of next of kin** |  | | |
| **Relationship to client** |  | | |
| **Current address**  Including post code |  | | |
| **Contact Number** |  | **Email** |  |

|  |  |
| --- | --- |
| **Address client will**  **be returning to if different from current/normal home address** |  |

|  |
| --- |
| **Please describe any particular needs or wishes related to disability, culture, ethnicity, beliefs etc?** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Interpreter needed?**  Delete as appropriate | **YES / NO** | **Does patient have literacy or numeracy support needs?**  Give details |  |

**Section 2: Programme/support request**

|  |  |
| --- | --- |
| **Programme Preference**  Delete as appropriate | Recovery Model/SMART  12-Step  No preference |

|  |  |
| --- | --- |
| **Other support needs**  Delete as appropriate and provide details below | Mental health  Physical health  Trauma issues  Housing  Financial  Vocational  Relationships  Self-care/ activities of daily living  Pregnancy  Other – give details below |
|  | |

**Section 3: Aftercare plans**

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| --- |
| **Please describe the client’s aftercare plans and how they address all relevant needs identified above e.g. move on to supported accommodation, move away from current address** |
|  |

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| --- |
| **What are client’s strengths / resources**  e.g. family, friends, housing, finances, hobbies, interests, skills, qualifications, work, spirituality/ politics/ beliefs, problem solving/ coping skills/ resilience, sources of support previous experiences of recovery etc |
|  |

|  |
| --- |
| **What are their goals / hope for attending Kenward and afterwards?** |
|  |

**Section 4: Referring service / team**

|  |  |
| --- | --- |
| **Name of team** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name** | **Landline** | **Mobile** | **Email** |
| **Keyworker/ care manager** |  |  |  |  |
| **Responsible clinician? (consultant or manager)** |  |  |  |  |
| **Lead contact/s) during referral/admission**  **other than keyworker**  (e.g. keyworker on leave) |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer’s email** |  | **Funding agreed?**  Delete as appropriate | **YES / NO** |
| **Referrer’s address**  Including post code |  | | |

Assessment of the client will normally be by remote (e.g. MS Teams) or face to face meeting with the Kenward Trust consultant and a member of Kenward Trust staff with referrer or team member present.

Other professionals involved in community care: **ALL** details **MUST** be supplied for referrals to be processed

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Details** | **Name** | **Role** | **Organisation** | **Address** | **Contact no** | **Email** |
| **Social worker**  (if applicable) |  |  |  |  |  |  |
| **GP**/**Surgery:** |  |  |  |  |  |  |
| **Mental health / CMHT** |  |  |  |  |  |  |
| **Probation officer** |  |  |  |  |  |  |

**Other agencies involved**: e.g. midwife, housing. Therapist, Adult social care

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Details** | **Name** | **Role** | **Organisation** | **Address** | **Contact no** | **Email** |
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**Section 5: Detox**

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| --- | --- |
| **Does client require medically managed detox?**  Delete as appropriate | **YES** - in-patient  **YES** - community detox  **NO** |
| **If YES, please provide details/dates below:** | |
|  | |

**For clients requiring in patient detox**

|  |  |
| --- | --- |
| **Has patient been assessed by in patient detox?**  Delete as appropriate | **NO** - referral not made yet  **NO** - referral made but no assessment date  **YES** |
| **If YES, give date if known:** |  |

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| --- | --- |
| **Has patient been accepted by detox?**  Delete as appropriate | **NO** - assessment outcome pending  **YES** - Date of admission offered  **YES** - Date of admission still pending |
| **If YES, give date if known:** |  |

**Section 6: Drug/ alcohol history**

**Please include if known e.g. illicit, prescribed and over-the-counter medication, and issues with gambling, gaming etc**

|  |
| --- |
| **Please describe presenting pattern of drug and alcohol use including prescription drugs**  **Include Alcometer readings, SADQ score and other relevant rating scales,**  **How has the service users drug use/ drinking behaviour impacted on their health, welfare and that of others. Include personal statement (if available).** |
|  |

**Urine drug screen results: please note that we require negative urine results for 10 days prior to admission. If this is not possible, consider referral for in patient detoxification**

**Clients will be tested on admission and will not be admitted if testing positive unless we are aware of or have agreed to admit with a positive test result.**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Opioids** | **Cocaine** | **Methadone/ EDDP** | **BUP** | **BDZ** | **Gabapentinoids** | **Other e.g. ketamine** |
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| **Does the service user currently inject?** Delete as appropriate | YES / NO | **If YES, where is the injecting site/sites?**  Delete as appropriate | Arms | Legs | Hands | Feet | Groin | Neck  Other: |

|  |  |
| --- | --- |
| **Does the service user currently share injecting equipment?** Delete as appropriate | **YES / NO / NOT KNOWN** |
| **Has the service user ever shared injecting equipment?**  Delete as appropriate | **YES / NO / NOT KNOWN** |
| **Blood borne viruses and vaccination history:** |  |

**Section 7: Past alcohol/ Substance use**

Please include solvents and prescription drugs.

|  |
| --- |
| **Please describe:**   * Age of first use * Any previous maintenance/ detox treatments/ rehabs etc, * Periods of abstinence, “swapping” of problem substance. * Any behavioural addictions (problems with gambling, gaming, food, sex / pornography etc) * Reasons or triggers for relapse |
|  |

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| **Has the client ever left or been discharged from detox/ rehab early for instance due to mental health problems, use of drugs of alcohol on site, forming relationships etc?**  If **YES**, please give details below: |
|  |

**Section 8: Medical history**

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| **Please list the service users past medical history and medical comorbidities (e.g. from GP records).**  Also include any acute or chronic medical concerns that may help to prioritise the referral (please see *Eligibility* section 16 and *Prioritisation* section 17)  Include dental history/ problems.  We recommend clients review any outstanding medical or psychiatric issues with their GP or local specialist before being attending Kenward Trust as registration with local services takes time. |
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**Section 9: Medication history**

Current prescribed medications by GP.

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| --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Indication** |
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Is the patient taking any medication with abuse or addictive potential?

Where such medications are prescribed/ taken illicitly a full assessment of this must be carried out and discussed with GP, other prescribers, rehab units. e.g. per NICE guidelines 215.

**Clients may be taking such medications long term without previous assessment**.

**We recommend routinely asking about gabapentinoid use and drug testing for this**

Please provide details

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes, illicit** | **Yes, prescribed** |
| Benzodiazepines e.g. diazepam |  |  |  |
| Z drug e.g. zopiclone |  |  |  |
| Opioid analgesia (codeine, tramadol etc) |  |  |  |
| Pregabalin or gabapentin |  |  |  |

|  |
| --- |
| **List all known drug allergies or intolerances** |
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| --- |
| **Is patient taking any herbal or over the counter medication?**  Some medications like Nurofen plus or Cannabidiol oil may not be taken into Kenward Trust.  If **YES**, give details below: |
|  |

**Section 10: Mental Health**

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| --- |
| **Please list the service users past and current psychiatric history (e.g. depression, suicidal ideation, psychosis, mental health admissions).**  Include any concerns about undiagnosed mental health conditions including ADHD and Autism. |
|  |

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| --- |
| **Please list any admissions to psychiatric hospital especially those under the mental health act (S136, S2, S3 etc)**  Please note that for clients with suspected or known ADHD or autism the care pathway for this remains the responsibility of home/ local services. |
|  |

|  |  |
| --- | --- |
| **Does the client have support from mental health services currently**  Delete as appropriate | **YES / NO** |
| **Has a CMHT referral been made but declined?**  Delete as appropriate | **YES / NO** |

|  |
| --- |
| **Please provide details of current/ recent mental health care (within the last 12 months)**. |
|  |

**NB: If clients are open to or recently open to mental health services/CMHT the referral to Kenward Trust must be discussed with that team.**

The mental health care of such clients remains the responsibility of home / local services unless specifically agreed with the Kenward Trust consultant.

**Section 11: Trauma-Informed Care**

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| **Please describe any relevant trauma related issues, or PTSD, which may affect care in detox and rehab, with details.** |
|  |

**Section 12: Family/personal history**

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| --- |
| **Please give a summary of family/personal history** |
|  |

**Section 13: Risk Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Risk** | **Yes** | **No** | **N/K** | **Current risk and any other details (e.g. date of last episode):** |
| Previous deliberate self-harm |  |  |  |  |
| Any history of ligaturing |  |  |  |  |
| Previous suicide attempts/ overdoses |  |  |  |  |
| Current suicidal ideation |  |  |  |  |
| Past history of violence (whether convicted or not), include violence related to mental health disorders.  Please supply additional details in sections 16/18 as appropriate |  |  |  |  |
| Past history of arson |  |  |  |  |
| Involvement in high-risk sexual behaviour |  |  |  |  |
| Cognitive impairment, confusion |  |  |  |  |
| Has patient been known to adult social care, deemed to be a vulnerable adult or concerns about vulnerability |  |  |  |  |
| Has serious physical health issues or unmet physical needs |  |  |  |  |
| History of seizures, collapse, sudden bleeding, hypoglycaemia or other acute medical problem |  |  |  |  |
| Difficulties with group work e.g. social anxiety, tendency to withdraw or isolate |  |  |  |  |
| Forensic history including driving whilst unfit |  |  |  |  |
| Sexual offences or inappropriate sexual behaviour |  |  |  |  |
| Eating disorder or disordered eating, especially during / following detox |  |  |  |  |

|  |  |
| --- | --- |
| **Problems with falls/ mobility / incontinence / self-care/ managing medication?** Delete as appropriate | **YES / NO** |

|  |
| --- |
| **If YES, Please describe e.g.**  Does person require/ use any aids when getting up from bed, sitting position, walking e.g. sticks / frames?  Can person get in and out of bath / shower unaided?  Can they dress unaided?  Do they normally have continence problems? if so do they normally wear pads  Do they normally have carers coming in or family supporting self-care?  Do they need prompting with self-care?  Do they have wound care needs? If so, are community nurses involved / a wound care package in place?  NB: patients should bring in supplies of specialist wound care products as these may take time to source once client admitted |
|  |

**Section 14: Aggression or Violent behaviour**

|  |
| --- |
| **Please give details of any aggression or violent behaviour - especially to staff or other clients** |
|  |

**Section 15: Childcare and dependents**

|  |  |
| --- | --- |
| **Does the client have responsibility for children < 16 years old**  Delete as appropriate and if YES, please specify below | **YES / NO** |
|  | |

|  |  |
| --- | --- |
| **Does the client have sole care?**  Delete as appropriate and if YES, please specify childcare arrangements during admission: | **YES / NO** |
|  | |

|  |  |
| --- | --- |
| **Have any childcare agencies been involved?**  Delete as appropriate and if YES, please provide contact details below: | **YES / NO** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency name** |  | | |
| **Lead contact/s** |  | | |
| **Address**  Including post code |  | | |
| **Contact Number** |  | **Email** |  |

**Section 16: Legal/ forensic issues**

|  |  |  |  |
| --- | --- | --- | --- |
| **Does/is the client** | **Yes** | **No** | **Provide details (e.g. index offence, duration, details of probation officer, wearing tag)** |
| - on probation/ tag |  |  |  |
| - have outstanding police warrants or charges |  |  |  |
| - currently in prison |  |  |  |
| - other current legal problems |  |  |  |
| - Past offending (especially violent/ sexual) |  |  |  |

|  |
| --- |
| **Please provide any additional information e.g. known to MAPPA/MARAC:** |
|  |

**Section 17: Unplanned discharge (“Plan B”)**

|  |
| --- |
| **Arrangements in case of unplanned discharge (“Plan B”)** |
|  |

**Section 18: Exclusion criteria**

Kenward Trust cannot accept clients who are subject to deprivations of liberty including S2/3 MHA, DOLS requirements or likely to become subject to them, nor patients who are actively suicidal or self – harming or pose a risk of harm to others.

We cannot accept patients with acute or severe mental health problems, especially without a “Plan B” involving local mental health services.

We cannot accept residents with any previous sexual conviction or unspent arson convictions.

No aftercare plan or appropriate step-down accommodation in place for the service user.

Excessive risk of violence and aggression or no assessment of such risk.

Bedbound or severely frail who are unable to transfer without assistance.

**Section 19: Service user Consent and referrer sign off**

Service users **must sign a handwritten signature** theconsent to admission and to information-sharing at the end of this form. Please discuss with us if obtaining consent is difficult.

|  |  |
| --- | --- |
|  | **Signature** |
| I confirm that the reasons for my admission to specialist rehabilitation have clearly been explained to me |  |
| All aftercare options for post rehab aftercare have been discussed with me. |  |
| I consent to my GP and other medical, social care and professionals to sharing information about me to support my care and treatment. |  |

|  |  |
| --- | --- |
| **Service user name:**  Please print |  |
| Signed: |  |
| Date: |  |

|  |  |
| --- | --- |
| **Referrer name:**  Please print |  |
| Signed: |  |
| Date: |  |