



# ***HAFAN WEN***

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## **Residential Treatment Referral Form**

**Client Name:** \_\_\_\_\_

**D.O.B:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Town:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Post Code:** \_\_\_\_\_

**Safe Telephone Number:** \_\_\_\_\_

**G.P. (name):** \_\_\_\_\_

**G.P. Surgery:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Town:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Drug/Alcohol Community Worker:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Other Professionals Involved:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_

**Agreed Length of Stay:** \_\_\_\_\_

**Agreed Nominated Visitor(s):** \_\_\_\_\_

\_\_\_\_\_

**Agreed Child Visitor(s):** \_\_\_\_\_

\_\_\_\_\_

**Person Attending with Child:** \_\_\_\_\_

**Child Care Issues (Comment):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Residential Treatment Assessment

	Current Drug and Alcohol Use	Prescribed	By Whom	Amount	Frequency	Route
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

	Other Medication to be Continued	Prescribed	By Whom	Amount	Frequency	Route
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____	_____

## Residential Treatment Assessment Form

**Detoxification/Stabilisation/Reduction Plan:**

<b><u>Previous Detox Information</u></b>	<b><u>Comments</u></b>
<b>Previous Detox? (Circle)</b> Yes              No  <b>If yes, where? (Circle)</b> Inpatient        Home  <b>Detox Successful? (Circle)</b> Yes              No  <b>Periods Substance Free:</b> _____	

<b><u>Existing/Previous Issues</u></b>	<b><u>Comments</u></b>
<b>Forensic Status:</b> _____  <b>Pending Court Cases:</b> _____  <b>Mental Health Issues:</b> _____  <b>Outstanding Appointments:</b> _____  <b>Known Allergies:</b> _____  <b>Hep B Inoculation?</b> _____  <b>If yes – Date:</b> _____	

<b><u>After Care Plan</u></b>	<b><u>Comments</u></b>
<b>Rehab Referral? (Circle)</b> Yes              No  <b>Funding Assessment Date:</b> _____  <b>Funding Agreed? (Circle)</b> Yes              No  <b>Location and Date of Agreed Rehab:</b> _____  <b>Social Issues:</b> _____	

## Patient Consent

**Part 1: To be completed after CDAS Assessment**

Information is needed by CAIS in preparation for your admission to Hafan Wen.

I hereby consent to this referral information being forwarded to CAIS.

**Signed (Client):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signed (Worker):** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please include Risk Assessment and Care Plan