

# GP REFERRAL FORM

Please email: [harccg.haga@nhs.net](mailto:harccg.haga@nhs.net)

Or fax: 020 8801 4619 (Attn: Duty Worker) & call 0208 800 6999 to confirm receipt

Referrer Name		Date of Referral	
Agency		Telephone	
R/ship to Client		Email	

Client Name		Ethnicity	
Date of Birth		Gender	
Address		Can we send mail?	YES NO
Telephone No/s		Can leave message?	YES NO
Skype Name		Online Appointment	YES NO

Client's pattern of Alcohol/ Drug use in last 28 days (frequency & amount per day)	
Age of first use	

Patient Goal	Reduction	Cessation
Is the client aware of the referral?	YES	NO
Children	YES	NO

Details (inc. name/dob for children, carer/guardian status)

Medical history, including medicines and mental health

Criminal Justice Issues	YES	NO
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Details



Date **AUDIT** completed: \_\_\_\_\_ (NB: must be in past two weeks, and done with client)

Questions	Scoring system					Your score
	0	1	2	3	4	

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking? (See <i>unit guidance above</i> .)	1-2	3-4	5-6	7-9	10+	
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

**SCORING**

**0-7 Lower risk**

**8-15 Increasing risk**

**16-19 Higher risk**

**20+ High risk/possible dependence**

**TOTAL \_\_\_\_\_**