

Homeless Specific\* Short-term Addiction Treatment (BBV Stabilisation Respite Unit)

Island House, Island Street, Ushers Island

Dublin 8

Tel: (01) 649 8620

**Referral Form**

**CONSENT (GDPR requirement):**

By Checking this box, I, *(referrer)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,*confirm that I have received written consent from the client, *(name of client)\_\_\_\_\_\_\_\_\_\_\_\_\_\_* to share the above personal data with you and that this written consent is stored securely within our service

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# Criteria for Admission

1. Clients who are HIV+ and/ Hepatitis C (antigen+).
2. Male/Female over the age of 18 years.
3. Clients registered as homeless with any of the four local authority, clients who are eligible for registration as homeless or have been in contact with a homeless agency.
4. Clients at risk of homelessness who have been recently housed and have a keyworker with Housing First or Tenancy Sustainment Services in the Dublin City and Dublin County area.
5. Certified fit for admission for drug stabilisation.

Please post the completed form to Dublin Simon Community, Homeless \* Short-term Addiction Treatment (BBV Stabilisation Respite Unit), Island House, Island St Usher’s Island, Dublin 8. Faxed copies cannot be accepted.

Please note, we cannot put your client on our waiting list if the form is incomplete or relevant additional detail is not included with the referral form. This may lead to delays in your client being admitted.

# 1.0 Doctors Letter Certifying Client Fit For Drug Stabilisation Programme

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

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

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**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical / Psychiatric History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please confirm that the client you are referring is either Hepatitis C (antigen+) and/ HIV +**

**Current Medication, dose, frequency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dispensing Pharmacist:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Phone and Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is client suitable to undergo Drug Stabilisation? Y  N**

**Signature of Doctor:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MCN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# 2.0 Client Details – PLEASE WRITE CLEARLY and answer all questions.

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| --- | --- |
| **First Name:**  **Surname:**  **Date of Birth:**  **Age:**  **Male  Female**  **Registered as homeless with Dublin City or Dublin County Local Authority (tick):**  **Y  N**  **If not, is the client eligible to be registered?**  **Y  N** | **Accommodation Type:**  **Rough Sleeper Local AuthorityOwn**  **NFA  B&B  Friends/Shared**  **Family  Hostel  Night Shelter**  **Hospital Private Rented**  **Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client’s current contact address:**  **Client’s contact number:** |
| **Country of origin:**  **Level of spoken English (if relevant)**  **Do you have an up to date Medical card?**  **Y  N**  **Are you in receipt of a social welfare payment?**  **Y  N**  **If Yes, what type of payment and on what day do you collect your payment:** | **Referred by (Name & Agency):**  **Address of Referrer :**  **Phone Number:**  **Email address:** |
| **Next of Kin:**  **Address:**  **Phone no:**  **Can we call this person if we need to contact you?**  **Y  N** | **Name of GP:**  **Address:**  **Phone:**  **Email:**  **Treatment for Blood Borne Virus**  **Name of Consultant:**  **Hospital:\_\_\_\_\_\_\_\_\_\_\_\_ Engaged W/ clinic: Y / N** |

# 3.0 Your Consent – Please list all services which you access from the list below and give contact details. If not applicable please write N/A.

|  |  |
| --- | --- |
| **Contact Details of professionals that may need to be contacted by staff in the stabilisation Respite Unit** | |
| **Social Worker/Counsellor Name:**  **Address:**  **Phone:**  **Email:** | **Outreach or Key Worker Name:**  **Address:**  **Phone:**  **Email:** |
| **Methadone Prescriber:**  **Address:**  **Phone:**  **Email:** | **Day Services:**  **Address:**  **Phone:**  **Email:** |
| **Probation Officer:**  **Address:**  **Phone:**  **Email:** | **Psychiatrist:**  **Address:**  **Phone:**  **Email:** |
| **GP:**  **Address:**  **Phone:**  **Email:** | **Other (e.g. Community Psychiatric Nurse, Solicitor etc.):** |

# 4.0 Discharge Plan

The BBV stabilisation Respite Programme is a three – five week short term treatment intervention. We provide Drug Stabilisation (not detoxification), clients have the opportunity to reduce illicit substance use and stabilise on their prescribed medication. It is the responsibility of the referral agency to have a discharge plan and move on options explored prior to admission and for this to be documented in the referral form. Please outline the plan and include where the individual will be returning to upon discharge from Stabilisation Respite programme. (Attach additional pages if required)

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# 5.0 Alcohol and Drug History

Please record your drug and alcohol usage over the past 7 days and state how it has been taken e.g. injection (I), oral (O) or snort/smoke (S/S)

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| --- | --- | --- | --- | --- |
| **ALCOHOL HISTORY** | | | | |
| Type of alcohol consumed : (e.g.) VODKA | | | | |
| Average consumption | PLEASE CIRCLE | DAILY | WEEKLY | MONTHLY |
| AMOUNT: |  | | |
| **DRUG HISTORY** | | | | |
| Type(s) of drugs used: | | | | |
| How are drugs taken? (P.O; IV; Smoked; Snort; Skin; Pop) | | | | |
| Frequency of use in last month: | | | | |

# 6.0 Methadone Maintenance Referral Procedures

|  |  |
| --- | --- |
| **Prescriber:**  **Address:**  **Phone:**  **Email:**  **Key worker/Counsellor** |  |

If the client is on daily methadone from a clinic, we require that they get their usual dose for three consecutive days prior to admission.

# 6.1 Things you need to know before admission

1. You will be required to stay in the unit for the first 3 days of your stay (Inclusive of day of admission).
2. If you have a phone, please provide a contact phone number as this will help us speed up your admission to the Stabilisation Respite Unit.
3. If you are coming from secure accommodation, please bring enough clothing and toiletries for your three week stay only. **We will not be able to hold belongings for you post discharge.**
4. Visitors are not permitted to the Respite Unit to promote a safe and recovery focused environment.

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**