



## Short-term Addiction Treatment Referral Form (Alcohol/Benzodiazepine Detox)

This form should be completed by the client's case worker in full in order to refer a client to the Dublin Simon community residential detox program. This form will be printed for use.

Homeless Specific\*  
Short-term Addiction Treatment  
(Alcohol/Benzodiazepine Detox)  
32/33 Blessington Street, Dublin 7

**D07 PF20**

Tel: (01) 6498601

### Detox Referral Form

**Referrer Data Protection declaration:**

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

This referral cannot proceed until this declaration is completed.

**Referrer Signature:**

**Date of referral:**

### Criteria for Admission

1. Male/Female over the age of 18 years.
2. Clients registered as homeless with a Dublin City or Dublin County local authority or who are eligible for registration as homeless.
3. 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
4. Clients on methadone are accepted (see 9.0)
5. Certified medically fit for a benzodiazepine **and/or** alcohol detox by a medical practitioner.

**Please post the completed form to the address at the top of this form. Fax copies will not 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.



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**1. Doctors Letter Certifying Client Fit for Detox Programme  
(Alcohol and/or Benzodiazepine)**

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

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

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

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

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

**Is client medically fit to undergo an alcohol and/or benzodiazepine detoxification? Y  N**

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

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

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



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<p>Phone no: _____</p> <p>Can we call this person if we need to contact you? Y <input type="checkbox"/> N <input type="checkbox"/></p>	
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**3. Your Consent – Please list all services which you access from the list below and give contact details.**

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

**4. Discharge Plan**

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The Detox Programme is a three-week short-term treatment intervention. 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.

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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)

Drug of choice	Day 1	Day 2	Day 3	Day 4	Day 5	Mode of Use	How long at this level?	Prior Use
Alcohol								
Methadone								
Heroin								
Cocaine								
Crack cocaine								
Benzodiazepine Prescribed (type & dose)								
Benzodiazepine Unprescribed Zimmovalnes (type and dose)								
Cannabis								



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Other									
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### 6. Methadone Maintenance Referral Procedures

<b>Prescriber:</b> <b>Address:</b>  <b>Phone:</b> <b>Email:</b>  <b>Key worker/Counsellor</b>	
<b>Urine Test Results (1)</b>  <b>Date Sample Taken</b>  <b>Results</b>	<b>Urine Test Results (2)</b>  <b>Date Sample Taken</b>  <b>Results</b>

6.1 If the client is on daily methadone from a clinic, we require that they get their usual dose for seven consecutive days prior to admission. Two recent clean urines (free from cocaine and opiates) and taken over two consecutive weeks need to be submitted with the referral form.

**Data protection notice to client:**  
 “The information you submit on this form is used to assess your suitability for the service. If your application does not progress we will dispose of this form after 1 month. If you are accepted into the service this form will be kept on your file.”

## 7. Things you need to know before admission

- (1) You will be required to stay in the unit for the first 7-10 days of your stay. For the first 24 hours after admission we will ask you to leave your phone with the nurse.
- (2) If you have a phone, please provide a contact phone number as this will help us speed up your admission.
- (3) These items are not allowed on the unit and your bag will be searched for them:



Alcohol



Drugs



Prescribed Medication



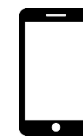
Weapons

- (4) We will carry out regular urine and breath tests for non-prescribed and alcohol



drugs

- (5) We will ask to keep your mobile phone for the first 24 hours of your



stay

- (6) Rent is €56 euro per week and is collected every Friday



- (7) Here are some things that you will need to bring with you:



Clothes



Money for rent/  
Cigarettes



A towel

- (8) You will be provided with a safe in your room, the detox unit is not responsible for your belongings.



- (9) We regularly carry out room searches for the safety and protection of



clients

- (10) You have the right to appeal any decision made in relation to your



referral

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Referrer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_