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| MILDMAY’S REBUILD PATHWAY (intermediate drug and alcohol residential rehab) |
| **REFERRAL FORM** |
| **ADDRESS**: 19 Tabernacle Gardens, London, E2 7DZ | Telephone: Ext:Email: Mobile:  |
| **Referral guidance**1. Please complete section 1 to 14 in full
2. Refer to section 16 to 18 for eligibility, prioritisation and exclusion
3. Service users must provide consent to treatment (section 14)
4. Completed forms should emailed to admissions.mildmay@nhs.net
 |  |
| **1. Service user details** |
| Name:  | Alias: | D.O.B:   | Age: | Gender:  |
| Address: Post code:Lives alone: Yes [ ]  No [ ]  | Temporary Address  | [ ]  |  |
| Hostel | [ ]  |
| NFA: borough connection | [ ]   |
| Own tenancy | [ ]  |
| Borough connection…H/F | *Please state* |
| Next of Kin name:  |  |  |  |  |  |  |  |
| Address: |  |  |  | Relationship: |  |  |  |
|  |  |  |  | Telephone No: |  |  |
| Post code: |  |  |  | Other form of contact: |  |
| Ethnicity:  |  |  |  |  |  |  |
| White | [ ]  | Black | [ ]  | Mixed | [ ]  | Other | [ ]  |
| British | [ ]   | Irish | [ ]  | European | [ ]  | Caribbean | [ ]  |
| African | [ ]  | Asian | [ ]  | SE Asian | [ ]  | Other | [ ]  |
|  |  |  |  |  |  |  |  |  |  |
| Interpreter needed? | Yes [ ]  | No [ ]  | Religion/spiritual needs | *Please state* |
| **2. Referring substance misuse team** |
| Name:  | Lead contact(s) during admission: |
| Address: Post code: | 1.  |
| 2.  |
| Telephone No.:  | Mobile No.:  |
|  |  |
| E-mail address:  |
| Borough funding admission: | *Please state* |  | Funding agreed:  | Yes [ ]  | No [ ]  |
| CHAIN number: … | *Please state* |  |  |  |  |
| Notice of admission date required? |  |  |  |  |
| Same day | [ ]  | 1 day | [ ]  | 2 days | [ ]  | 1- 2 weeks | [ ]  |
| **3. Substance misuse history**  |
| Please include if known *e.g., illicit, prescribed and over-the-counter medication (misused)* |
| Substance/medication  | Age of first use | Duration of use | Frequency of use |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| Current substance use:  |
| Substance | Route | Average daily amount (e.g., in £ or grams, alcohol use in units) |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| Please provide the current details of the dispensing pharmacy where appropriate: |
| Pharmacy Name:  | Script details (e.g. methadone/buprenorphine, dose, supervised consumption) |
|  |
| Address: Post code: | 1.  |
| 2.  |
| Telephone No. | Mobile No.: |
|  |  |
| E-mail address:  |
| Has the service user previously been prescribed Take Home Naloxone?  | Yes [ ]   | No [ ]   |  |
| Has the service user ever received training for Take Home Naloxone?  | Yes [ ]   | No [ ]   |  |
| Does the service user currently inject?  | Yes [ ]   | No [ ]   |  |
| Injecting site(s): | Arms [ ]  | Legs [ ]  | Hands [ ]  | Feet [ ]  | Groin [ ]  | Neck [ ]  | Other [ ]  |
| Does the service user currently share injecting equipment?  | Yes [ ]   | No [ ]   |  |
| Has the service user ever shared injecting equipment?  | Yes [ ]   | No [ ]   |  |
| **4. Addiction treatment history** |
| Past treatment and detoxification (in chronological order) including location and length of time if known |
| Date | Community | Inpatient | Rehab | Outcome (period of abstinence) |
|  |  |  |  |  |
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| How has the service users drug use/ drinking behaviour impacted on their health? |
| Please give details… |
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|   |
|  |
|  |
| **5. Medical history** |
| Current GP practice:  | GP name:  |
| Address: Post code: | 1.  |
| 2.  |
| Telephone No.  | Mobile No. |
|  |  |
| E-mail address:  |
|  |  |  |  |  |  |  |  |  |  |
| 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) |
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| Seizure history: | Yes [ ]  No [ ]   |
| Have seizures occurred during alcohol withdrawal  | Yes [ ]  No [ ]   |
| If yes, have multiple seizures (>1) occurred during alcohol withdrawal | Yes [ ]  No [ ]   |
| Do seizures occur during drug withdrawal e.g. benzodiazepines | Yes [ ]  No [ ]   |
| Do seizures occur outside of alcohol/drug withdrawal | Yes [ ]  No [ ]   |
| Please detail any other known patterns: |
|  |  |  |  |  |  |  |  |  |  |
| Current prescribed medications (include dose and frequency): |
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|  |  |  |
|  |  |  |
| List all known drug allergies: |
|  |  |  |
|  |  |  |
| Blood borne viruses and vaccination history: |
|   | Date tested | Result | Outcome or treatment/vaccination (include dates) |
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|  |  |  |  |
| Covid-19 and vaccinations: No vaccinations |
| Has the service user had coronavirus? Yes [ ]  No [ ]   | Date… | Please state |
| Covid-19 vaccine 1st dose | Date… | *Please state* | Covid-19 vaccine 2nd dose | Date… | *Please state* |
| **6. Mental Health** |
| 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. |
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| Does the service user have support from a CMHT?  | Yes [ ]  No [ ]  |
| Has the CMHT been informed of the service user’s admission? | Yes [ ]  No [ ]  |
| CMHT Name: | Lead CMHT contact(s): |
| Address:Post code: | 1.  |
| 2.  |
| Telephone No.: | Mobile No.: |
|  |  |
| E-mail address:  |
| **7. Referral summary** |
| Please detail the leading reasons as to why acute hospital specialist treatment is required referencing the eligibility criteria to aid prioritisation (section 16 and 17) |
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| Client motivation and goals: |
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| **8. Risk Assessment** |
| Please complete below or include the most recent (within 3 months) risk assessment as an attachment |
| Risk |  | Current risk and any other details (e.g., date of last episode): |
| Previous deliberate self-harm | Yes [ ]  No [ ]  |  |
|  |  |  |
|  |  |  |
| Previous suicide attempts/ overdoses | Yes [ ]  No [ ]  |  |
|  |  |  |
|  | N/K [ ]  |  |
| Current suicidal ideation/ low affect | Yes [ ]  No [ ]  |  |
|  |  |  |
|  |  |  |
| Significant past history of violence | Yes [ ]  No [ ]  |  |
|  |  |  |
|  | N/K [ ]  |  |
| Current thoughts/plans indication a risk of  | Yes [ ]  No [ ]  |  |
| violence |  |  |
|  |  |  |
| Past history of arson | Yes [ ]  No [ ]  |  |
|  |  |  |
|  | N/K [ ]  |  |
| Has injecting related viral infection | Yes [ ]  No [ ]  |  |
|  |  |  |
|  | N/K [ ]  |  |
| Involvement in high-risk sexual behaviour | Yes [ ]  No [ ]  |  |
|  |  |  |
|  | N/K [ ]  |  |
| Cognitive impairment | Yes [ ]  No [ ]  |  |
|  |  |  |
|  |  |  |
| Has serious physical health issues or unmet | Yes x[ ]  No [ ]  |  |
| needs |  |  |
|  |  |  |
| Contact with Social Services or Children’s  | Yes [ ]  No [ ]  |  |
| Services |  |  |
|  |  |  |
| Forensic history | Yes [ ]  No [ ]  |  |
|  |  |  |
|  |  |  |
| Sexual offences or inappropriate sexual | Yes [ ]  No [ ]  |  |
| behaviour |  |  |
|  |  |  |
| **9. History of aggression or violent behaviour** |
| Please give details and dates where applicable: |
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| **10. Childcare and dependents** |
| Does the service user have responsibility for children < 16 years old | Yes [ ]  No [ ]  |
| Please specify… |
|  |
| Does the service user have sole care? | Yes [ ]  No [ ]  |
| Please specify childcare arrangements during admission: |
|  |
| Have any childcare agencies been involved? | Yes [ ]  No [ ]  |
| If yes please provide contact details: |
| Agency name: | Lead contact(s): |
| Address:Post code: | 1.  |
| 2.  |
| Telephone No.: | Mobile No.: |
|  |  |
| E-mail address:  |
| **11. Companion dogs and kennelling** |
| Does the service user have a dog(s) | Yes [ ]  No [ ]  |
| If yes, has kennelling been agreed with Dogs on the Streets charity? | Yes [ ]  No [ ]  |
| Please provide details (start date, time of kennelling agreed):  |
|  |
| Contact phone number: | E-mail address: |
| **12. Legal** |
| Does/is the service user |  | Provide details |
| - on probation | Yes [ ]  No [ ]  |  |
| - have outstanding police warrants or charges | Yes [ ]  No [ ]  |  |
| - currently in prison | Yes [ ]  No [ ]  |  |
| - other | Yes [ ]  No [ ]  |  |
| Please provide any additional information: |
|  |
| **13. Discharge arrangements** |
| **Please complete in full. All service users must have an aftercare plan in place prior to their admission to the Guy’s & St Thomas’ ACCS. All referrals without prior discharge planning will be rejected (please see *Exclusion criteria* Section 18).**  |
| Does the service user: |  | Provide details |
| - have an aftercare plan in place? | Yes [ ]  No [ ]  |  |
| - have step down accommodation? | Yes [ ]  No [ ]  |  |
| - require a Day Programme? | Yes [ ]  No [ ]  |  |
| - require residential care? | Yes [ ]  No [ ]  |  |
|  |
| **If yes to any of the above, please provide details where appropriate:** |
| **Step down accommodation:** | Lead contact: |
| Address:Post code: |  |
| Availability date:  |
| Telephone No.: | Mobile No.: |
|  |  |
| E-mail address:  |
|  |  |  |  |  |  |  |  |  |  |
| **Day Programme:** | Lead contact: |
| Address:Post code: |  |
| Availability date:  |
| Telephone No.: | Mobile No.: |
|  |  |
| E-mail address:  |
|  |  |  |  |  |  |  |  |  |  |
| **Residential care:**  | Lead contact:  |
|  | Manager  |
| Availability date:  |
| Telephone No. | Mobile No.: |
|  |  |
| E-mail address:  |
|  |  |  |  |  |  |  |  |  |  |
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|  |
| **Agency: Social worker** | Lead contact:  |
| Address:Post code: | Booking date: |
| Booking reference: |
| Telephone No.: | Mobile No.: |
|  |  |
| E-mail address:  |
| **14. Service user Consent** |
| I confirm that the reasons for my admission to hospital for specialist inpatient treatment have clearly been explained | Yes [ ]  No [ ]  |
| I confirm that I have had the opportunity to ask questions relating to my care and have had these answered satisfactorily | Yes [ ]  No [ ]  |
| I agree to admission to the Guy’s & St Thomas’ Addiction Clinical Care Suite and aftercare planning | Yes [ ]  No [ ]  |
| I understand that the information collected about me will be used to support my care plan  | Yes [ ]  No [ ]  |
| I confirm that my care can be discussed with my partner, friends or family  | Yes [ ]  No [ ]  |
| I understand that I cannot have visitors during my specialist inpatient treatment and the reason for this have been explained | Yes [ ]  No [ ]  |
| Has the service user been offered a copy of this referral form? | Yes [ ]  No [ ]  |
| If no, please provide details… |
|  |
| Service user name:  | *Please print* | Signed:  | *Please sign* |
|  | Date: |
|  |
| Completed by : | *Please print* | Signed:  | *Please sign* |
|  | Date of referral: … |
| Please email completed referral to: admissions.mildmay@nhs.net |  |

**Referral guidelines**

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| **15. Checklist** |
| All service users referred to the pathway must have been received inpatient detox from ACCS via their local community substance misuse team or another acute hospital  |
| All referrals must fulfil the following checklist to be accepted: |  | *Refers to:* |
| Service users are in contact with and being referred by the community substance misuse team and have on-going support | Yes [ ]  No [ ]  | *Section 2, 7, 13* |
| Trusted assessor approach including comprehensive clinical assessment (nursing and or medical) to help inform the Mildmay care plan.  | Yes [ ]  No [ ]  | *Section 3 to 9* |
| Community substance misuse teams are satisfied that service users have demonstrated engagement, preparation for detox and expectation of follow on treatment plan and housing journey, evidence of discussion of an ambition to move towards recovery and long-term housing | Yes [ ]  No [ ]  | *Section 3, 4, 14* |
| Details of housing provision or appropriate step-down offer in place post detoxification (further detoxification, community rehabilitation, residential rehabilitation)  | Yes [ ]  No [ ]  | *Section 13* |
| **16. Eligibility criteria** |
| 1. 18 years of age or older
 |
| 1. Have had in-patient Admission for detoxification of alcohol and or drugs in people who are homeless who have complex needs (e.g. medical comorbidities) that otherwise are considered too unstable to be treated elsewhere
 |
| 1. There is no limit on alcohol use
 |
| 1. Opioid users will be assessed for detoxification on a case-by-case basis. Clients opioid use may have been stabilised as part of community substance misuse treatment, but this is not a pre-requisite for entry
 |
| **17. Prioritisation** |
| Please indicate any of the following criteria in the medical history of the referral form (section 5) as this will help prioritise the referral. This list is not exhaustive and other acute/chronic comorbidities will be considered |
| 1. Pregnant women: referrals for service users who are pregnant will be assessed on a case by case basis with the community substance misuse team clinician and the ACCS MDT. Admission to the ACCS will be dependent on the stage of pregnancy, the treatment required and assessment through an across site MDT including maternity services
 |
| 1. Services users with diagnosed severe and enduring mental health illness
 |
| 1. Opioid and poly drug users with high risk behaviours such as high risk injecting including injecting into femoral blood vessels at the groin; injection related thrombosis and infection/abscesses; sexual risk behaviour
 |
| 1. High risk complicated alcohol withdrawal (previous delirium tremens, seizures, arrhythmias)
 |
| 1. Evidence of current alcohol-related morbidity (reduced cognition, regular seizures)
 |
| 1. Dependent drinkers who have complex medical comorbidities requiring clinical assessment or in whom detoxification may result in a subsequent deterioration of their medical health. This includes a history of, but is not limited to:
 |
| Cardiovascular: * + - heart failure
		- cardiac arrhythmia’s
		- myocardial infarction within the last 12 months
		- stable angina
		- uncontrolled hypertension
 |
| Respiratory: * + - smoking related airway disease - severe COPD (FEV1 <50% predicted), very severe COPD (FEV1 <30% predicted), or ≥2 exacerbations per year, or one or more requiring hospitalisation
		- haemoptysis not investigated
 |
| Gastrointestinal:* + - known alcohol related liver disease at risk of decompensation (e.g., known varices, stable ascites, stable jaundice, coagulopathy e.g. INR >1.4)
		- BMI <18.5 with unintentional weight loss (≥5% body weight in 6 months) or malnutrition
		- risk of refeeding syndrome
		- severe vomiting and diarrhoea
 |
| Renal:* + - chronic renal failure (eGFR < 45 ml/min, Stage 3b to Stage 5)
 |
| Neurological: * + - recent stroke within 12 months
		- significant cerebellar ataxia and unable to mobilise independently
		- falls resulting in head injury with intracranial bleed within the last 12 months
		- frequent seizures due to epilepsy
 |
| Endocrine* + - poorly controlled diabetes mellitus
		- electrolyte imbalance e.g. severe hyponatraemia (serum sodium <125mmol/L)
 |
| Oncology* + - suspected cancer or known cancer requiring treatment
 |
| Infection* + - known HIV or Hepatitis C not receiving treatment
		- injection site abscess or related limb swelling that may indicated thrombosis or an infected thrombosis
 |
| **18. Exclusion criteria** |
| The predominate reason for exclusion to the ACCS will be: |
| 1. No evidence of engagement in the assessment or care planning process towards detoxification by community substance misuse teams event at referral
 |
| 1. No planned or availability of short term or stepdown accommodation prior to detoxification
 |
| 1. Excessive risk of violence and aggression based on a community substance misuse risk assessment based on a Trusted Assessor approach
 |
| Individuals may be re-referred to the ACCS if the reasons for a previously rejected referral have been mitigated via the local authority or community substance misuse team. |