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| **For S****Change, grow, live****CGL Warwickshire.** **Please send a referral to :****E-fax: 01926 328658****Tel: 01926 353513****Criminal Justice Referrals:** **warwickshire.referrals@cgl.cjsm.net****All other referrals:** **Warwickshire.Info@cgl.org.uk** **(please ensure the file****Is password protected) alternatively use the fax number above****Please complete this form in full with as much information as possible.** |  |
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| ReferrAL TYPE |
| PrisonReferral | DRR Referral | ATR referral | Court Referral | ConditionalCaution | PPO/ Testing on Licence | Required Assessment/Follow up | Children’s Services  | Self Referral |  GP | Social Services | Alcohol Services |
| □ | □ | □ | □ | □ |  □ |  □ | □ |  □  |  □ |  □ | □ |
| Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of sentence and court \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Service User Information |
| Client Name |  | DOB |  |
| Address  |  | Telephone |  |
| GP Name & Address |  | GP Tel. No. |  |
| DIVERSITY MONITORING  |
| Ethnic Origin |
| White -British  |  White - Ir Irish | White -Other | Mixed -White and Black Caribbean | Mixed – White and Black African | Mixed – White and Asian | Mixed -Other | Asian or Asian British - Indian | Asian or Asian British - Pakistani | Asian or Asian British - Bangladeshi | Asian or Asian British - Other | Black or Black British -Caribbean | Black or Black British - African | Black or Black British - Other | Chinese or other ethnic group - Chinese | Chinese or other ethnic group – Other | Not Stated |
| □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ |
|  Religion | Previously treated  |
| No religion |  Christian |  Catholic |  Buddhist |  Hindu | Jewish | Muslim |  Sikh | Atheist/ agnostic | Any other religion | Not stated |  Yes □ No □  |
| □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Referral Information |
| Problematic Alcohol use (**including AUDIT score**) |  |
| Problematic drug use (including OTC) |   |
| Referral source Information |
| Referrer’s Name | Self-referral | Telephone | n/a |
| Organisation | n/a | Fax | n/a |
| Address | n/a | Email | n/a |

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|  Priorty/risk management  |
| Mental Health  |  Yes □ No □ | Housing/Homeless | Yes □ No □ |
| Child Protection / Children’s Services  | Yes □ No □ | Domestic Violence | Yes □ No □ |
| Pregnant | Yes □ No □ | Vulnerable Adult/Safeguarding | Yes □ No □ |
| IV User | Yes □ No □ | Sex Worker | Yes □ No □ |
| Children under age of 5  | Yes □ No □ Children’s Ages................... | Client consent for CGL to contact | Yes □ No □ |
| Any other information (Please indicate any known risks) |
|  |

**For CGL use only**

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| Date referral received |  |
| Date of assessment appointment |  | Time of assessment appointment |  |
| Assessment Worker |  | Office  |  |