|  |  |  |  |
| --- | --- | --- | --- |
| **Details of person being referred:** | | | |
| Name: |  | Date of birth: |  |
| Gender: |  | Ethnicity: |  |
| Address: |  | Post code: |  |
| Contact no.: |  | Is it OK to call/text? | o Yes o No |

|  |  |  |
| --- | --- | --- |
| **Moving On Service**  person is being referred for: | o | Early Intervention Service |
| o | Main Moving On Programme |
| o | New Roots in Recovery Programme (Justice Services) |
| o | Relapse Support |
| o | Family Support |
| Brief reason person is being referred to Moving On: |  | |

|  |  |
| --- | --- |
| **Background to referral (where appropriate):** | |
| Current substance / alcohol use (state all non-prescribed substances currently being used): | How often used (daily, weekly, etc.) and amount being used: |
|  |  |
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|  |  |
|  |  |
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| --- | --- |
| **Previous history** of substance / alcohol use (including when last used if known): |  |
| Known **physical health** considerations: |  |

|  |  |
| --- | --- |
| Known **mental health** considerations: |  |
| Details of known **current prescribed medications**: |  |
| Other **relevant information** (please include any risks we need to be aware of): |  |

|  |  |
| --- | --- |
| **Referrer’s details** | |
| Name: |  |
| Agency: |  |
| Email: |  |
| Telephone no.: |  |
| Referral date: |  |

|  |  |
| --- | --- |
| Has referral been discussed with service user? | o Yes o No |

|  |  |
| --- | --- |
| Outcome of referral (Moving On staff use only) |  |
| **Moving On Inverclyde contact details** | |
| Telephone:  Email:  Address:  Website: | 01475 735 200  [contact@movingoninverclyde.co.uk](mailto:contact@movingoninverclyde.co.uk)  Kingston House, 3 Jamaica Street, Greenock PA15 1XX  [www.movingoninverclyde.co.uk](http://www.movingoninverclyde.co.uk) |

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