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**Open Access Referral Form**

* Support for women who would like advice, help or guidance concerning their drug or alcohol use.
* Please return completed forms to referrals@oasisproject.org.uk

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| CLIENT NAME |  |
| Name of person completing this form, including organisation (if applicable) and contact details*If you are making a self-referral, leave this section blank* |  |
| Date referral made |  |
| Date of Birth |  |
| Ethnicity |  |
| Address*Postcode must be BN1, BN2, BN3 or BN41* |  |
| Telephone Number |  |
| Email Address |  |
| Can we contact you by: | *Please indicate* |
| Phone | Yes/No |
| Text message | Yes/No |
| Voicemail | Yes/No |
| Email | Yes/No |
| Letter | Yes/No |
| Current problems with drugs / alcohol. Which substance(s)? Quantity and frequency? |  |
| Are you currently in treatment? If so, what’s the name of your care coordinator? |  |
| How did you hear about Oasis? |  |
| Is this the first time you have contacted us? |  |
| Do you have any disabilities or access requirements? | Yes / no |
| Do you have any children? If yes, what are their ages? |  |
| If yes, do they need a crèche space? |  |
| Is there anything else you’d like to tell us? |  |
| For office use only: IF ALCOHOL AND PARENT BOOK IN WITH FAMILY PRACTITIONER |  |
| APPOINTMENT DATE/TIMEAdd to spread sheet with your initials and client contact number.  |
| Risks we should be aware of, including concerns from other services, risks to self and/or others. |  |
| Any other relevant information |  |
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