

*This form should be used for all referrals to Kaleidoscope Alcohol Service. If the client is present, please ensure that they sign the consent statement on page 2. To supplement this referral, clients should also be asked to complete the AUDIT screening questionnaire on page 3.  
Referrals for significant others who require support from us should be made on a significant others contact form.*

**Client Details**

<b>First Name</b>	<b>Surname</b>	<b>D.O.B</b>
<b>Gender M / F</b>	<b>Telephone / Mobile:</b>	
<b>Address</b>		
		<b>Postcode:</b>

**GP Details (if known)**

**Referrer's Details**

<b>Name:</b>	<b>Agency:</b>	<b>Tel:</b>
<b>Referral feedback required? YES / NO</b>		<b>Is the client aware of the referral? YES / NO</b>
<b>Current Alcohol use</b>	<b>Has the client undertaken AUDIT?</b> <small>(if no, please do this if possible)</small>	<b>Y / N</b> <b>AUDIT Score:</b> <input type="text"/>

**Please describe clients current alcohol intake** (amount per day / number of days per week, etc)

**Use of other substances** (include prescribed drugs and length of time used)

**What are the main presenting problems?**

**Risk and Priority** (please circle any that are known)

Pregnant	<b>Yes / No</b>	Risk of being harmed by others	<b>Yes / No</b>
Childcare issues	<b>Yes / No</b>	Is a risk to others	<b>Yes / No</b>
Injecting drug use	<b>Yes / No</b>	Homelessness	<b>Yes / No</b>
Ever overdosed	<b>Yes / No</b>	Lives alone	<b>Yes / No</b>
Sexual health concerns	<b>Yes / No</b>	Is under 19	<b>Yes / No</b>
Physical health concerns	<b>Yes / No</b>	Has just been or is about to be released from Prison?	<b>Yes / No</b>
Mental health concerns	<b>Yes / No</b>	Criminal behaviour / is involved with the criminal justice system	<b>Yes / No</b>
Has self harmed or is talking about self harm	<b>Yes / No</b>		<b>Yes / No</b>

**Any additional risks / further information?**

Are there any other agencies providing services to the client that you are aware of?

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Will the client have any difficulties in accessing services? (please circle)

Disabled      Transport      Childcare      Employment      Translator      Other

Please briefly expand:

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**Permission for Kaleidoscope Alcohol Service to contact the client:**

By letter	Yes / No
By phone (Please state which mobile / telephone or both)	Yes / No
Permission to leave a message on: Answer-phone	Yes / No
Text Message	Yes / No
Permission for Kaleidoscope Alcohol Service to contact your GP	Yes / No

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**I consent to:**

Information being shared with referrer about the outcome of my appointment / treatment	Yes / No
Information being shared with my GP about the outcome of my appointment / treatment	Yes / No
The details of this form being sent to the above agency I am being referred to	Yes / No

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**Consent Statement (to be signed by client)**

I understand that these details will be passed on to Kaleidoscope Alcohol Service who will contact me in order to carry out a more detailed assessment. I am aware that I have requested this referral to be made and that anonymous details will be used to monitor service delivery. I understand that the agency I'm being referred to will offer me an appointment by post / telephone and that they will carry out a more in-depth assessment of my needs, however this may not be the agency that provides my treatment if it is felt that another service may be more suitable.

Client's signature ..... Date.....

PLEASE FAX THIS FORM TO KALEIDOSCOPE ALCOHOL SERVICE  
FAX NUMBER **01291 635356**

**Kaleidoscope Alcohol Service**  
The Junction  
Cedar House  
Station Road  
Chepstow. NP16 5PB

Tel: 01291 635355  
Fax: 01291 635356

[alcohol@kaleidoscopeproject.org.uk](mailto:alcohol@kaleidoscopeproject.org.uk)

## The Alcohol Use Disorders Identification Test (AUDIT)

In order for us to find out a little bit more about your drinking, please answer the following questions. Your answers will remain confidential so please be honest, it will help us to understand a bit more about you and what the best way forward will be. Please circle your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	