



**BROADREACH
ACTION FOR CHANGE**

STRUCTURED DAY SERVICE ▪ RESETTLEMENT
VOCATIONAL TRAINING ▪ AFTERCARE ▪ SUPPORT SERVICES

Supporting You in Rebuilding Your Life

APPLICATION FOR TREATMENT

*Please complete ALL sections
of the form and send to*

**Broadreach Action for Change
Ocean Quay
Richmond walk
Plymouth
PL1 4LL**

**or fax to
01752 500450**

**or email to
dayservice@broadreach-house.org.uk**

Tel: 01752 500003

Basic Information

Full Name

Date Of Birth **Age**

Sex M F

Current Address.....

.....

Post Code

Tel. No.

daytime.....

evening

mobile

Accommodation Need (Please tick appropriate box)

NFA – urgent housing problem

Housing problem

No housing problem

DAT of residence.....

PCT of Residence.....

FOR OFFICE USE ONLY

Referral Date.....

Date of Assessment.....

Start Date

IMPORTANT CONTACTS

Next of kin/ emergency contact:

Name/relationship

Address

Tel. number

Referring agency (if applicable)

(care-manager /social worker)

Name.....

Agency Name

Address.....

Tel. no..... Fax No:

Funding agency (if different from referring agency)

Name.....

Agency Name

Address.....

Tel. no..... Fax No:.....

Care Manager (If different from funder/referrer)

Name

Agency Name

Address.....

Tel. no..... Fax No:

GP/ Doctor

Name.....

Address

Tel. no.

IMPORTANT CONTACTS (2)

Psychiatrist/CPN (if applicable)

Name.....

Address.....

Tel. no.

Probation officer (If applicable)

Name.....

Address

Tel. no.

EQUAL OPPORTUNITIES MONITORING

The next two questions are for Equal Opportunities monitoring and will not affect your application for treatment

Ethnic group *All groupings taken from the ONS (Office of National Statistics)*

White British White Irish White Other *please specify*

White & Black Carribean White & Black African White & Asian

Other mixed *please specify*

Indian Pakistani Bangladeshi Other Asian

Carribean African Other Black Chinese

Other *please specify*

Nationality

.....

Religion

None Christian (C of E/Catholic/ Protestant/other denominations)

Buddhist Muslim Jewish Sikh

Other

FINANCIAL/ EMPLOYMENT

Current employment status

Employed (Regular) Unemployed Pupil/Student

Economically Inactive (Pensioners/Housewives/-men/Invalids)

Other

Usual, or most recent occupation.....

Are you currently receiving any DSS benefits? Yes No

If yes, please give details

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FAMILY

Which family members or close friends are especially supportive of your seeking treatment?

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Number of dependent children (under 18)

How many children? None 1 2 3 4+

Any children under 18? If so how many?

Please state Ages.....

Are you pregnant? Yes No

Location of children:

All the children live with you Some of the children live with you

None of the children live with you Not a parent

Decline to answer

LEGAL ISSUES

Do you have any pending Court Cases/Bail Conditions? Yes No

If yes, please give details, offence, court date, etc.

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Are you currently on probation or parole? Yes No

Are you on a DRR (Drug Rehabilitation Requirement)? Yes No

Are you on an ATR (Alcohol Treatment Requirement)? Yes No

Are you on a Tag/Curfew? Yes No

If ticked yes to any of the above please give brief details:

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How many criminal offences have you ever been charged with?

None 1 2 3 4+ If more than 4 how many ?

Have you ever been convicted of the following:

Violent offence Yes No If yes please give details (including when)

.....

Arson Yes No If yes please give details (including when)

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Sexual offence Yes No If yes please give details (including when)

.....

What legal problems have you had during the last few months?

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MEDICAL & PSYCHIATRIC

If you have experienced any of the following health problems please let us know (and provide brief details:

Medical condition	Yes	No	Details
Fits			
Jaundice/liver damage			
Diabetes			
Heart trouble			
Vomitting blood recently			
Abscesses			
Hosp admission in last 4 weeks			
Asthma			
Eating problems			

Do you have any other health issues or problems ? Yes No
 If yes please give brief details (including any treatment received)

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Please list ALL current prescribed medication

Medication	Amount e.g. mg	How long taken	Medication taken for ?

Medications, Vaccinations and Testing

Have you been vaccinated against Hep B? Yes No

If yes, how many vaccinations have you had? 1 2 3 Full Course

Have you had a previous Hep B infection? Yes No

Have you been tested for Hep C? Yes No

If yes, latest test date

Are you Hep C positive? Yes No

Have you been referred to Hepatology? Yes No

Do you require a test for Hep C? Yes No

Height.....Weight.....

Do you have any allergies (e.g medication/food etc) ? Yes No

If yes please give details

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Do you have any particular dietary requirements ? Yes No

If yes please give details

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Are you currently receiving care from Mental Health Services for

reasons other than Substance Misuse? Yes No

If yes, please give brief details - if you are currently receiving any form of psychiatric treatment or medication, please include details of this and the name/ contact information of the psychiatrist.

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Have you ever been treated for a psychiatric condition? Yes No

If yes, please give brief details, please include details of this and the name/ contact information of the psychiatrist.

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Have you ever attempted suicide? Yes No

Have you ever self-harmed? Yes No

If yes to either of these please give brief details including dates etc.

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ALCOHOL & DRUG USE

What substances do you currently have problems with?

Alcohol Heroin Crack Cannabis Cocaine Ecstasy
LSD Methadone Amphetamines Benzodiazepines
Other

What amounts of each have you been using during the last three months?

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What is your problem substance No.1 ?

Frequency of use of problem substance No.1?

Not used in past month Used once pw or less Used 2-6 days pw
Used daily Used more than once daily Not known

Age first used problem substance No.1:

Route of administration of problem substance No.1:

Inject Smoke Sniff Oral Other.....

What is your problem substance No.2 ?

What is your problem substance No.3 ?

Injecting information:

Currently Injecting Previously Injected (not currently) Never

Have you ever shared drug paraphernalia/equipment? Yes No

Age first Injected:

Have you injected in last 30 days? Yes No

What other substances have you ever used?

Alcohol Heroin Crack Cannabis Cocaine Ecstasy
LSD Methadone Amphetamines Benzodiazepines
Other

Alcohol

On how many days in the last 30 have you drunk alcohol?

How many units would you consume in a typical day?

YOU AND TREATMENT

Have you ever had treatment for drug/alcohol problems? Yes No

Have you ever been treated by a structured community based drug treatment service or had residential treatment for your drug/alcohol problem? Yes No

If yes, give details below

Name of agency/treatment centre (including Broadreach/Longreach/Closereach)	Date/length of time in treatment eg. 1993/ 1 month	Outcome

Have you ever attempted to stop using/drinking without treatment?

Yes No

If yes, describe what happened

(how successful you were and for how long, etc.)

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ANYTHING ELSE

Is there anything else about you or this application that you feel we need to know ?.....

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Thank you for taking the time to fill out this form. We will process your application for treatment as soon as possible

How did you hear about us ?

Care-manager/drug/alcohol agency

GP

Word of mouth

Broadreach website

Other website details

Other details

All information provided will be treated confidentially

Consent Form

Broadreach House is required to submit anonymised Data to the National Drug Treatment Monitoring System. Do you consent to your Data being submitted? Yes No

Please Sign.....

Please also sign this authority for release of information to enable your application to proceed.

I give permission for all care professionals with whom I have been involved to release to Broadreach any relevant information, which may be required. Broadreach may release to the following agencies such details as may be required for treatment, funding and research purposes (delete as appropriate):

- Named Care Co-coordinator/Manager
- Probation Officer (if applicable)
- Social/Family Services (if applicable)
- General Practitioner
- Psychiatrist and/or CPN (If applicable)
- Housing Services (If applicable)
- Emergency Services

Please list below any individuals/services to whom you do NOT wish any details to be released to:

.....
.....

Name (PRINT PLEASE):

Signed:

Date of Birth:

Address:

..... Post Code: