



# APPLICATION FOR TREATMENT

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

**Broadreach House  
465 Tavistock Road  
Plymouth, Devon  
PL6 7HE**

or fax to

**01752 569260**

or email to

**admissions@broadreach-house.org.uk**



**Direct line to Assessments Team 01752 797100**

**What type or length of treatment are you ideally looking for:**

Broadreach: detox only Yes  No

Broadreach: longer term rehabilitation up to 6 weeks Yes  No

Closereach: longer-term rehabilitation treatment – Male only Yes  No

Longreach: longer-term rehabilitation treatment - Female only Yes  No

*(NOTE- this form is to be used for all applications for residential treatment at Broadreach House (Broadreach, Closereach & Longreach)  
We will discuss your precise treatment requirements during your assessment.*

**Basic Information**

**Full Name** .....

**Date Of Birth** ..... **Age** .....

**Sex** M  F

**Current Address**.....  
.....

**Post Code** .....

**Tel. No.**

daytime.....

evening .....

mobile .....

<p><b>FOR OFFICE USE ONLY</b></p> <p>Referral Date.....</p> <p>Date of Assessment.....</p> <p>Start Date .....</p> <p>Client reference number .....</p>
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# **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: .....

Email address:.....

## **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: .....

Email address.....

## **GP/ Doctor**

Name.....

Address .....

Tel. no. ....

**Psychiatrist/CPN (if applicable)**

Name.....

Address.....

Tel. no. ....

**Probation officer (If applicable)**

Name.....

Address .....

Tel. no. ....

**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

## **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** .....

**DAT of residence**.....

**PCT of Residence**.....

**Sex Worker:** Are you...

Selling sex from a premises  Selling sex from the street

Not a sex worker

**Accommodation Need** (Please tick appropriate box)

NFA – urgent housing problem

Housing problem

No housing problem

## **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

.....

**National Insurance number** .....

# **LEGAL ISSUES**

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

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

.....

**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)

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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)

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

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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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**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 .....

.....

**Do you have any particular dietary requirements ?** Yes  No

If yes please give details .....

.....

## **MEDICAL & PSYCHIATRIC**

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

<b>Medical condition</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
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**

<b>Medication</b>	<b>Amount e.g. mg</b>	<b>How long taken</b>	<b>Medication taken for ?</b>

## **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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## **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 ? .....**

**Age first used problem substance No.1: .....**

**Route of administration of problem substance No.1:**

Inject  Smoke  Sniff  Oral  Other.....

**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

**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 injected in last 30 days? Yes  No

Have you ever shared drug paraphernalia/equipment? Yes  No

Age first Injected: .....

**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 28 have you drunk alcohol?**

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**How many units would you consume in a typical day?**

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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:**

.....  
.....

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Name (PRINT PLEASE): .....

Signed: .....

Date of Birth: .....

Address: .....

..... Post Code: .....

**Declaration of Truth (signature required)**

I certify that the information on this application is complete, accurate, and true; to the best of my knowledge and agree to abide by the policies and regulations of Broadreach House.

I understand that any information given falsely or withheld may affect the decision on my application and may make me ineligible for admission and/or treatment.

Applicant's Signature: .....

Date: .....