

# Strategies & Treatment for Alcohol Rehabilitation and Therapy – Referral

## Residential



Please complete this form in block capitals and fax to FAO Karen Bishop on: **01423 523338**  
or telephone for further information on **0845 070 4166**

### PATIENT DETAILS

|          |                    |
|----------|--------------------|
| SURNAME: | FORENAME(S):       |
| ADDRESS: | D.O.B:<br><br>TEL: |

Has the patient a history of:

|                 |        |                              |        |
|-----------------|--------|------------------------------|--------|
| Pancreatitis:   | Yes/No | Seizures/Fits:               | Yes/No |
| Liver Problems: | Yes/No | Physical Disabilities:       | Yes/No |
| Diabetes:       | Yes/No | Heart Problems:              | Yes/No |
| Heart Problems: | Yes/No | Oesophageal Varices:         | Yes/No |
| Overdose:       | Yes/No | Head Injury/Falls:           | Yes/No |
| Mental Illness: | Yes/No | Other general health issues: | Yes/No |

If yes to any of the above – Give details:

Has the patient recently had any of these investigations/procedures:

|               |        |   |        |
|---------------|--------|---|--------|
| FBC:          | Yes/No | CT or MRI Scan:                         | Yes/No |
| TFT:          | Yes/No | Admissions to hospital:                 | Yes/No |
| LFT with GGT: | Yes/No | Home Detoxes:                           | Yes/No |
| U & E's:      | Yes/No | Clotting Problems:                      | Yes/No |
| Ultrasound:   | Yes/No | Investigations at A & E or outpatients: | Yes/No |

If yes to any of the above – Give details:

|  |                    |
|--|--------------------|
| MEDICATIONS PRESCRIBED or KNOWN TO BE/HAVE TAKEN<br>(please attach print out if preferred) | GP – DETAILS/STAMP |
| SUPPORT/CARERS INVOLVED: YES/NO<br>If Yes give details:                                    |                    |