Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Integrated Alcohol Service Referral Form

Date of Referral:			
Name:		**D.O.B:**	**Ph:**
Address:			

Alcohol Use						
AUDIT-C- Questions	**Scoring System**					
	0	**1**	**2**	**3**	**4**	**Your Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 + times a week	
How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5 or 6	7- 9	10+	
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/ Almost daily	
Less than 5 low risk	**5+ Full AUDIT**				**Total**	

Any Additional Alcohol Issues: Y/N If yes, please give details: ____

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Drug Use Y/N If yes, please give details:

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Mental/Physical Health Issues Y/N If yes, please give details:

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GP/Prescribed Medication Y/N If yes, please give GP and medication(s) details:

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Any Additional Needs, (ie housing, etc):

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Referrer Name:	**Organisation:**
Address:	
Phone:	**Email:**

I/the client ______________________________________ **(client signature if possible) give verbal/written (please underline which) permission for staff in the Integrated Alcohol Service to communicate with the above-named referrer about the progress of this referral and discuss any relevant information in relation to my care which is provided by the services**. I/the client consent to having personal data processed and stored by the Integrated Alcohol Service for the purposes of providing the service requested. ☐ (Please tick box to confirm)

Please email all referrals to: iasdublinreferrals@hse.ie **If you have any queries please Ph: 01 856 6406**