**REFERRAL to CARE**

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| **Name:** | DOB: |
| Address: | Contact No: Medical Card: Yes/No |

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| **No of previous Alcohol Detoxes:**  Community Detoxes: Inpatient Detoxes:  Known complicated Detoxes:  Date of last Detox:  History of other Substance Abuse: | | **Medical Hx:**  Current Medications:  Blood Tests Results: | |
| **AUDIT-C: Please complete with patient and circle score**  1. How often did you have a drink containing alcohol in the past year?  Never (0 points score questions 2 and 3 as zero)  Monthly or less (1 point)  2 to 4 times a month (2 points)  2 or 3 times per week (3 points)  4 or more times a week (4 points) | 2.How many drinks did you have on a typical day when you were drinking in the past year?  1 or 2 (0 points)  3 or 4 (1 point)  5 or 6 (2 points)  7 to 9 (3 points)  10 or more (4 points) | | 3.How often did you have 6 or more drinks on one occasion in the past year?  Never (0 points)  Less than monthly (1 point)  Monthly (2 points)  Weekly (3 points)  Daily or almost daily (4 points) |

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| **Mental Health Concerns:** | **Current Alcohol Support Agency Involvement:**  **Name of Concerned Person: (closest family member/friend)** |

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| **Name of Referrer: Other information/ Comments :**  **Date of Referral:**  **Contact Number :** |