

SAOL Project C.E. Programme Referral Form

WHAT IS SAOL?

The SAOL Project is a client-centred, community-based day programme for women in treatment for drug addiction. Its C.E. programme aims to create positive, meaningful change through an integrated programme of education, rehabilitation, advocacy, childcare provision (with a focus on early childhood education), progression and aftercare supports. The SAOL C.E programme is one year in duration with the possibility of your client remaining for a second year depending on their progress in year one. We deliver a FETAC education programme and also provide psycho-social groups, one-to-one supports, addiction relapse supports, cocaine use interventions, family support & community support, based on a combination of motivational interviewing, CBT and CRA.

This referral form will be placed on our CE waiting list and your client will be called for interview in turn. You may be contacted at this time to give us any additional information that might be relevant to the referral.

1 Client Information

1.1 Client Name _____

1.2 Address _____

1.3 Date of Birth / /

1.4 Telephone No _____ 1.5 PPS No _____

2 Referrer Information

2.1 Referrer Name _____

2.2 Position held _____

2.3 Referral Agency _____

2.4 Address _____

2.5 Contact No _____

2.6 How long have you known your client? _____

2.7 How long more will you be working with this client? _____

2.8 Can you confirm that your client is currently attending an opioid replacement therapy programme?
 Yes No

3 Client Profile

3.1 Where does your client attend for drug treatment? _____

3.2 How many times per week does your client attend for their drug treatment? _____

3.3 Has your client attended consistently over the last six months? Yes No

3.4 What other medication, including benzodiazepines, is your client currently prescribed? (If not known, please tick box)

Medication	Daily Dosage
_____	_____
_____	_____
_____	_____

Not known

3.5 Name of prescribing doctor _____

3.6 Name of counsellor if any _____

3.7a Is your client *currently* being treated for depression or a psychiatric illness that we should be aware of?

Yes No Please state _____

3.7b Has your client *ever* been diagnosed with depression or a psychiatric illness that we should be aware of?

Yes No Please state _____

3.8 Are you aware of any circumstances which could hinder your client's full participation in SAOL?

Yes No

Explain _____

3.9 Do any of the services you provide, and that this client must attend, collide with the SAOL attendance time of 9.30 a.m. – 1.00 p.m. Monday to Friday?

Yes No

Explain _____

3.10 Is your client linked in with any other relevant support services or agencies?

Yes No

Describe

SAOL operates a service called 'SAOL Beag', a children's centre for pre-school children who are one years of age or older. SAOL also operates a 'Summer School' for older children (up to age 10) during school breaks. These services provide childcare for participants during class-time and also engage with children in an age-appropriate way as clients in their own right.

3.11 Does your client have any children that will be likely to avail of these services? If so, can you give us some details, including ages of the children?

3.12 Is there any additional information you would like to offer about your client?

3.13 Any other comments?

4 Client Drug Use

Please answer, based on your knowledge and perhaps also drug screening results, each of the following questions.

These questions relate to your client's drug use **during the last 3 months**.

- | | | | |
|--|------------------------------|-----------------------------|-------------------------------------|
| Has your client used heroin in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has your client used cocaine in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has your client used crack cocaine in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has your client used unprescribed tablets in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has your client used cannabis in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has your client topped up with methadone in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |
| Has alcohol been a problem for your client in the last 3 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't know <input type="checkbox"/> |

5 To The Referrer

6.1 Are you prepared, as the referrer, to engage in developing and progressing a care plan centred around your client's needs and to attend two meetings with the client in Year One of the SAOL Programme?

Yes No

6.2 Please select the most appropriate statement below regarding this referral

- I highly recommend my client as suitable for the SAOL C.E. programme and am willing to engage in developing a care plan with them.
- I am unsure whether my client is suitable for the SAOL C.E. programme at the moment but am willing to engage in developing a care plan with them and propose involvement in other SAOL services.
- Other statement _____

Signature of Referrer _____

Date _____

6 To The Client

Permission for SAOL Project to access urine results

I HEREBY GIVE PERMISSION FOR THE SAOL PROJECT TO ACCESS MY URINE RESULTS AND ANY OTHER INFORMATION REGARDING MY CURRENT PRESCRIBED MEDICATION. I UNDERSTAND THAT THIS INFORMATION IS ONLY NECESSARY TO VERIFY DRUG USE INFORMATION GIVEN ON THIS REFERRAL FORM. I UNDERSTAND THAT THIS INFORMATION WILL BE TREATED IN THE STRICTEST CONFIDENCE BY THE SAOL PROJECT AND NO OTHER AGENCY WILL HAVE ACCESS TO THESE RESULTS.

Signed (Client) _____

Date _____