

**Club Drugs Clinic; HSE National Drug Treatment Centre Referral Form**

Name: ........................................................ Name of Referrer:........................................................

Address:........................................................ Referrer’s Contact:.......................................................

...................................................................... GP’s Contact:.................................................................

Date of Birth:................................................ .......................................................................................

Contact Number(s):...................................... Date of Referral:............................................................

*Current GHB/GBL/Crystal Meth Usage (How much & How often):..........................................................*

*..................................................................................................................................................................*

*Use of other substances (Urine tox screen where available):...................................................................*

*..................................................................................................................................................................*

*Medical History*:.......................................................................................................................................

Concerns re: Substance Misuse & Related Behaviours:...........................................................................

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*Prescribed Medication*:.............................................................................................................................

*Psychiatric History*:...................................................................................................................................

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*Accidental/Intentional Overdoses & Outcomes*:......................................................................................

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*Social Circumstances (Accommodation & who living with)*:.....................................................................

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*Counselling & Support History & Current Engagement:...........................................................................*

*..................................................................................................................................................................*

*Post Detoxification Rehabilitation Plan:...................................................................................................*

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| For Office Use: | Outcome of Referral: |

The referral form can be emailed to cts@dtcb.ie or posted to:

The Club Drugs Clinic

HSE National Drug Treatment Centre

30-31 Pearse Street

Dublin 2

D02 NY26

For queries, contact the National Drug Treatment Centre on 01 6488600.