ÁIT LINN CENTRE INITIAL CONTACT / REFERRAL FORM Date of Referral _____Month_____

First Name_____Last Name_____

Date of Birth_____Age_____Gender Male Female

Address _____ Phone Number_____

_____ _____

_____

Dublin _____

Attended Before _____Are you a concerned person _____PD_____Both____

Referral Source : Hospital Mater Beaumont

GP _____Other_____Name of Referring Agent_____

Contact phone number of Referring Agent_____

Marital Status _____Children Number : _____Ages :_____

Living with them:_____Stable Accomodation __Yes___No_____

Psychiatric History or underlying condition such_____History of self harm_____

Employed _____Full time _____Part time_____Social Welfare_____

Support Person_____

Current Drinking Status_____Sober_____Not Sober_____

No of Units Weekly_____

Motivation Assessment- answer the following

Looking for information Yes No

Looking to reduce alcohol intake Yes No

Looking to stop drinking Yes No

Looking to explore options Yes No

Have you a G.P. _____

GP Name_____

Address_____

_____

_____

Will they need a community detoxification _____

Are you on medication ? _____Prescribed_____Not Prescribed _____

Have you had a recent hospital stay in the past year to to years Yes No

How many times

0	1-3	3-5	5+

How many days

0	1-3	3-5	5+

Signed Client Name _____FAX TO : 01-5377362