Unit D1C Bluebell Industrial Estate, Kylemore Rd, Ballyfermot, Dublin 12, Ireland.
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Referee Name: ______________________ Agency Name: ______________________

Client Name: ______________________ Gender: Male ☐ Female ☐

Address: ____

____

Nationality: ______________________ Date of Birth: ____/____/_______ Age: __________

Living : Alone: ☐ Family: ☐ Partner: ☐ Other: ☐ Specify: ______________________

Mobile: ______________ House: ______________ PPS No: ______________

Next of Kin: Name: ______________________ Nature of Relationship: ______________________

Contact No: ______________________Do you have any children? Yes ☐ No ☐ If yes how many?__________

Any prior experience of counselling , support work? Yes ☐ No ☐

Name of Organisation ____

What agency are they working with at present? (Please list, voluntary, statutory etc...)

____

____

____

Do you have an allocated Case Manager? ☐ Yes ☐ No (If yes please give name and agency)

____

Have you completed a Holistic Needs Assessment? Yes ☐ No ☐ Care Plan? Yes ☐ No ☐

Reasons for contacting Liberties Recycling including work experience:

____

____

____

Do you have Medical Card: Yes ☐ No ☐ Are you currently employed? Yes ☐ No ☐

Are you registered for housing with local authority? Yes ☐ No ☐ If yes which local authority? ______________

Are you in receipt of Benefits? Yes ☐ No ☐ If yes which type? ______________________

What age did you leave school? ______________ Education highest level? ______________

Age you first used drugs at ______________________________

Which Drug? ______________________________________

Have you ever injected? Yes ☐ No ☐

If yes what age? ______________

Have you ever shared injecting equipment? Yes ☐ No ☐

Are you currently using any drugs? Yes ☐ No ☐

Current Drug Use

Substance including Alcohol and MethadoneAnd Prescription Drugs	Route of administration (i.e. IV, SM, Oral, Snort, rectal etc.…)	Frequency of use in last month (i.e. daily, weekly, not in last month)	Age at first use
main substance			
substance 2			
substance 3			
substance 4			

What is the name and contact details of the prescribing GP/Clinic? ____

____

Is the prescribing GP/Clinic aware of the clients referral YES ☐ NO ☐

Would they agree to support community detox protocols? YES ☐ NO ☐

for office use only

Details recorded by: ____________________________________ Date: __________________

Brought to Team Meeting on: ____/___/____ Date of first App: ___/___/_____

Worker Allocated: ____

Made contact with client (Details): ____