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| **GUY’S & ST. THOMAS’ ADDICTIONS CLINICAL CARE SUITE (ACCS)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL FORM** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Pathway (Please Indicate)**  **ACCS 1 NFA, PEOPLE WHO SLEEP ROUGH, RISK OF RETURN TO THE STREET, RISK OF HOMELESSNESS, HOSTEL or UNSTABLE TEMPORARY ACCOMMODATION**  **ACCS 2 UNIVERSAL (not specific to people who sleep rough)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDRESS:**  Addiction Care Team, Block B, 2nd Floor  South Wing, St Thomas’s Hospital, London, SE1 7EH | | | | | | | | | | | | | | | | | | | Telephone: 0207 188 7188  Email: **ACCSReferrals@gstt.nhs.uk**  Mobile: **07731 591 611** | | | | | |
| **Referral guidance**   1. Please complete section 1 to 14 in full. 2. Refer to section 16 to 18 for eligibility, prioritisation and exclusion. 3. Service users must provide consent to treatment (section 14). 4. Completed forms should be scanned and emailed to the ACCS Referrers will be asked to attend an online ACCS MDT discussion. | | | | | | | | | | | | | | | | | | | | | | | | |
| **1. Service user details** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | Alias: | | | | | D.O.B: | | | | | | Age: | | | Gender: | | |
| Mobile No: | | | | | | | | | | | | | Telephone No: | | | | | | | | | | | |
| Address:  Post code:  Lives alone: Yes  No | | | | | | | | | | | | | Is the service user threatened with homelessness in the next 56 days (8 weeks):  Yes No | | | | | | | | | | | |
| Service users current housing situation:  Choose an item. | | | | | | | | | | | |
| NFA: | | | | | | | Borough connection: Choose an item. | | | | |
| Next of Kin name: | | | | | | | | | | | | | Relationship: | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | Telephone No: | | | | | | | | | | | |
| Other form of contact: | | | | | | | | | | | |
| Post code: | | | | | | | | | | | | |
| Disability (1): Choose an item.  Disability (2): Choose an item.  Disability (3): Choose an item.  ***Please use disability 2 & 3 if the patient reports more than one disability.*** | | | | | | | | | | | | | | Service users stated sexual orientation: Choose an item.  *Self-description details:* | | | | | | | | | | |
| Is the service user a veteran of the British Armed Forces? Choose an item. | | | | | | | | | | |
| Ethnic Origin: Choose an item. | | | | | | | | | | | | | Country of Birth: Choose an item. | | | | | | | | | | | |
| Religion/spiritual needs: Choose an item. | | | | | | | | | | | | | Employment status: Choose an item. | | | | | | | | | | | |
| Time since last paid employment: Choose an item. | | | | | | | | | | | | | Interpreter needed? Yes  No | | | | | | | | | | | |
| Any other assistance required? ***Please state*** | | | | | | | | | | | | | | | | | | | | | | | | |
| **2. Referring substance misuse team** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | 1. Name of the responsible clinician: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | 1. Lead contact(s) during admission: | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| Borough funding admission: Choose an item. | | | | | | | | | | | | | Funding agreed: | | | | | | Yes | | | No | | |
| CHAIN number: | | | | | | | | | | | | | | | | | | | | | | | | |
| Notice of admission date required? | | | | | | | | | | | | | | | | | | | | | | | | |
| Same day | |  | | | 1 day | | |  | | | | 2 days | | | |  | | | | 1-2 weeks | | |  | |
| **3. Substance misuse history** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please include if known *e.g. illicit, prescribed and over-the-counter medication (misused)* | | | | | | | | | | | | | | | | | | | | | | | | |
| Substance/medication | | | | | Age of first use | | | | | | | | Duration of use | | | | | | | Frequency of use | | | | |
| 1. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| 2. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| 3. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| 4. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| 5. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| 6. | | | | |  | | | | | | | |  | | | | | | |  | | | | |
| Current substance use: | | | | | | | | | | | | | | | | | | | | | | | | |
| Substance | | | | | Route | | | | Average daily amount *(e.g. in £ or grams, alcohol use in units)* | | | | | | | | | | | | | | | |
| 1. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| 2. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| 3. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| 4. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| 5. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| 6. | | | | |  | | | |  | | | | | | | | | | | | | | | |
| Please provide the current details of the dispensing pharmacy where appropriate: | | | | | | | | | | | | | | | | | | | | | | | | |
| Pharmacy Name: | | | | | | | | | | | | | Script details (e.g. methadone/buprenorphine, dose, supervised consumption) | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| Does the service user smoke cigarettes? | | | | | | | | | | | | | | | | | | | Yes | | No | | |  |
| Has the service user previously been prescribed Take Home Naloxone? | | | | | | | | | | | | | | | | | | | Yes | | No | | |  |
| Has the service user ever received training for Take Home Naloxone? | | | | | | | | | | | | | | | | | | | Yes | | No | | |  |
| Has the service user been administered with naloxone to reverse the effects of an overdose in the last 6 months? | | | | | | | | | | | | | | | | | | | Yes | | No | | |  |
| Does the service user currently inject? | | | | | | | | | | | | | | | | | | | Yes | | No | | |  |
| Injecting site(s): | | | | Yes | | | No | | |  | | | | | | | Feet | | Groin | | Neck | | | Other |
| Does the service user currently share injecting equipment? | | | | | | | | | | | | | | | | | | | Yes | | No | | | N/K |
| Has the service user ever shared injecting equipment? | | | | | | | | | | | | | | | | | | | Yes | | No | | | N/K |
| Has the service user ever been a victim or survivor of domestic abuse? | | | | | | | | | | | | | | | | | | |  | |  | | |  |
| **4. Addiction treatment history** | | | | | | | | | | | | | | | | | | | | | | | | |
| Past treatment and detoxification(in chronological order) including location and length of time if known | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | Community | | | | | Inpatient | | | | | Rehab | | | | | | | | | Outcome (period of abstinence) | | | | |
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| How has the service users drug use/ drinking behaviour impacted on their health? | | | | | | | | | | | | | | | | | | | | | | | | |
| Please give details… | | | | | | | | | | | | | | | | | | | | | | | | |
| **5. Medical history** | | | | | | | | | | | | | | | | | | | | | | | | |
| Current GP practice: | | | | | | | | | | | | | GP name: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| Please list the service users past medical history and medical comorbidities (e.g. from GP records).  Also include any acute or chronic medical concerns that may help to prioritise the referral (please see *Eligibility* section 16, and *Prioritisation* section 17) | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Seizure history: | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Have seizures occurred during alcohol withdrawal | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| If Yes, have multiple seizures (>1) occurred during alcohol withdrawal | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Do seizures occur during drug withdrawal e.g. benzodiazepines | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Do seizures occur outside of alcohol/drug withdrawal | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Please detail any other known patterns: | | | | | | | | | | | | | | | | | | | | | | | | |
| Current prescribed medications (include dose and frequency): | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of medication** | | | | | | | | **Dose** | | | | | | | | | | **Frequency** | | | | | | |
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| List all known drug allergies: | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | |  | | | | | | | | | |  | | | | | | |
| **Blood borne viruses and vaccination history:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Date tested | | | Result | | | Outcome or treatment/vaccination status (include dates) | | | | | | | | | | | | | | | |
| Hepatitis B | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| Hepatitis C | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| HIV | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| Tetanus | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| Covid-19 and vaccinations: | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the service user had Covid-19 vaccinations? Yes  No  N/K  Date: ***If known please state*** | | | | | | | | | | | | | | | | | | | | | | | | |
| **6. Mental Health** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please list the service users past and current psychiatric history (e.g. depression, suicidal ideation, psychosis, mental health admissions). *Include any concerns about undiagnosed mental health conditions and the* ***current treatment plan and/or referrals****.* | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the service user have support from a CMHT? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Has the CMHT been informed of the service users admission? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| CMHT Name: | | | | | | | | | | | | | Lead CMHT contact(s): | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| **7. Referral summary** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please detail the leading reasons for referral, referencing the eligibility criteria to aid prioritisation (section 16 and 17) | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the treatment request? i.e Stabilisation/detoxification. Please detail here: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Client motivation and goals: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **8. Risk Assessment** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please complete the risk assessment below (*please include dates of incidents*) | | | | | | | | | | | | | | | | | | | | | | | | |
| Risk | | | | | | | | |  | | | | | | Current risk and any other details (e.g. date of last episode): | | | | | | | | | |
| Previous deliberate self-harm | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Previous suicide attempts/ overdoses | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| N/K | | | | | |
| Current suicidal ideation/ low affect | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
|  | | | | | |
| Past history of violence | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| N/K | | | | | |
| Abused someone close to/know well | | | | | | | | | Choose an item. | | | | | |  | | | | | | | | | |
| Current thoughts/plans indication a risk of Violence | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Past history of arson | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| N/K | | | | | |
| Has injecting related viral infection | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| N/K | | | | | |
| Involvement in high-risk sexual behaviour | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| N/K | | | | | |
| Cognitive impairment | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Has serious physical health issues or unmet needs | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Contact with Social Services or Children’s Services | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Forensic history | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Sexual offences or inappropriate sexual behaviour | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
|  | | | | | |
| Victim or survivor of domestic abuse | | | | | | | | | Choose an item. | | | | | |  | | | | | | | | | |
| Received money or goods in exchange for sex | | | | | | | | | Choose an item. | | | | | |  | | | | | | | | | |
| **9. History of aggression or violent behaviour** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please give details and dates where applicable: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **10. Childcare and dependents** | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the service user have responsibility for children < 16 years old | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Please specify… | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the service user have sole care? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Please specify childcare arrangements during admission: | | | | | | | | | | | | | | | | | | | | | | | | |
| Have any childcare agencies been involved? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| If the child/children are receiving any social care help, please select:  Choose an item. | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes please provide contact details: | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency name: | | | | | | | | | | | | | Lead contact(s): | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| **11. Companion dogs and kennelling** | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the service user have a dog(s) | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| If yes, has kennelling been agreed with Dogs on the Streets charity? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Please provide details (start date, time of kennelling agreed): | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact phone number: 0800 999 8446 | | | | | | | | | | | | | E-mail address: hello@dogsonthestreets.org | | | | | | | | | | | |
| **12. Legal** | | | | | | | | | | | | | | | | | | | | | | | | |
| Does/is the service user | | | | | | | | | | | | | | | Provide details | | | | | | | | | |
| On probation | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Have outstanding police warrants or charges | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Currently in prison | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Other | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Please provide any additional information: | | | | | | | | | | | | | | | | | | | | | | | | |
| **13. Discharge arrangements** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please complete in full. All service users must have an aftercare plan in place prior to their admission to the Guy’s & St Thomas’ ACCS. All referrals without prior discharge planning will be rejected (please see *Exclusion criteria* Section 18).** | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the service user: | | | | | | | | |  | | | | | | Provide details | | | | | | | | | |
| Have an aftercare plan in place? | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Have step down accommodation? | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Require a Day Programme? | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| Require residential care? | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | |
| City of London have access to a range of residential rehab facilities. If you would like further details please contact Nadia.Adigbli@cityoflondon.gov.uk | | | | | | | | | | | | | | | | | | | | | | | | |
| **If yes to any of the above please provide details where appropriate:** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Step down accommodation:** | | | | | | | | | | | | | Lead contact: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | |  | | | | | | | | | | | |
| Availability date: | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
|  | | | | | | |  | | | | |
| E-mail address: | | | | | | | | | | | |
| **Day Programme:** | | | | | | | | | | | | | Lead contact: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | |  | | | | | | | | | | | |
| Availability date: | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
|  | | | | | | |  | | | | |
| E-mail address: | | | | | | | | | | | |
| **Residential care:** | | | | | | | | | | | | | Lead contact: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | |  | | | | | | | | | | | |
| Availability date: | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
|  | | | | | | |  | | | | |
| E-mail address: | | | | | | | | | | | |
| **Service users will require supervised transport from the Guy’s & St Thomas’ ACCS to their discharge destination** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide transport details: | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency: | | | | | | | | | | | | | Lead contact: | | | | | | | | | | | |
| Address:  Post code: | | | | | | | | | | | | | Booking date: | | | | | | | | | | | |
| Booking reference: | | | | | | | | | | | |
| Telephone No.: | | | | | | | Mobile No.: | | | | |
| E-mail address: | | | | | | | | | | | |
| **14. Service user Consent** | | | | | | | | | | | | | | | | | | | | | | | | |
| I confirm that the reasons for my admission to hospital for specialist inpatient treatment have clearly been explained | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I confirm that I have had the opportunity to ask questions relating to my care and have had these answered satisfactorily | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I agree to admission to the Guy’s & St Thomas’ Addiction Clinical Care Suite and aftercare planning | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I understand that the information collected about me will be used to support my care plan | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I confirm that my care can be discussed with my partner, friends or family | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I understand that I cannot have visitors during my specialist inpatient treatment and the reason for this have been explained | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| I consent and agree that my treatment provider and Guy’s & St Thomas’ Addiction Clinical Care Suite can share my personal information with OHID (Office for Health Improvement and Disparities) for the purposes outlined in NDTMS information and consent: [NDTMS: information and consent (accessible version) - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/confidentiality-guidance-for-drug-and-alcohol-treatment-providers-and-clients/ndtms-information-and-consent-accessible-version) | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| Has the service user been offered a copy of this referral form? | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| If no, please provide details… | | | | | | | | | | | | | | | | | | | | | | | | |
| Service user name:… | | | | | ***Please print*** | | | | | | | | Signed:… | | | | | | | ***Please sign*** | | | | |
|  | | | | | | | | | | | | | Date:… | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Completed by:… ***Please print*** | | | | | | | | | | | | | Signed:… ***Please sign*** | | | | | | | | | | | |
|  | | | | | | | | | | | | | Date of referral:… | | | | | | | | | | | |
| Please scan completed referral and email to: | | | | | | | | | | | | | **ACCSReferrals@gstt.nhs.uk** | | | | | | | | | | | |

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| **Referral guidelines** | | |
| **15. Checklist** | | |
| All service users referred to the pathway must have been assessed as appropriate for acute hospital specialist treatment with the ACCS via their local community substance misuse team | | |
| All referrals must fulfil the following checklist to be accepted: |  | *Refers to:* |
| Service users are in contact with and being referred by the community substance misuse team and have on-going support | Yes  No | *Section 2, 7, 13* |
| Trusted assessor approach including comprehensive clinical assessment (nursing and or medical) to help inform the ACCS care plan. | Yes  No | *Section 3 to 9* |
| Community substance misuse teams are satisfied that service users have demonstrated engagement, preparation for detox and expectation of follow on treatment plan and housing journey, evidence of discussion of an ambition to move towards recovery and long-term housing | Yes  No | *Section 3, 4, 14* |
| Details of housing provision or appropriate step-down offer in place post detoxification (further detoxification, community rehabilitation, residential rehabilitation) | Yes  No | *Section 13* |
| **16. Eligibility criteria** | | |
| 1. 18 years of age or older | | |
| 1. Admission is for detoxification of alcohol and or drugs (including stabilisation) in people who are homeless or who are at risk homelessness. Admission is also for the universal pathway, persons who may have complex needs (e.g. medical comorbidities) that otherwise are considered too unstable to be treated elsewhere. | | |
| 1. There is no limit on alcohol use | | |
| 1. Opioid users will be assessed for detoxification/stabilisation on a case by case basis. Clients opioid use may have been stabilised as part of community substance misuse treatment, but this is not a pre-requisite for entry | | |
| 1. The service user has an aftercare plan or appropriate step-down accommodation in place (as detailed in Section 13) | | |
| **17. Prioritisation** | | |
| Please indicate any of the following criteria in the medical history of the referral form **(section 5)** as this will help prioritise the referral. This list is not exhaustive and other acute/chronic comorbidities will be considered | | |
| 1. Pregnant women: referrals for service users who are pregnant will be assessed on a case by case basis with the community substance misuse team clinician and the ACCS MDT. Admission to the ACCS will be dependent on the stage of pregnancy, the treatment required and assessment through an across site MDT including maternity services | | |
| 1. Services users with diagnosed severe and enduring mental health illness | | |
| 1. Opioid and poly drug users with high risk behaviours such as high-risk injecting including injecting into femoral blood vessels at the groin; injection related thrombosis and infection/abscesses; sexual risk behaviour | | |
| 1. High risk complicated alcohol withdrawal (previous delirium tremens, seizures, arrhythmias) | | |
| 1. Evidence of current alcohol-related morbidity (reduced cognition, regular seizures) | | |
| 1. Dependent drinkers who have complex medical comorbidities requiring clinical assessment or in whom detoxification may result in a subsequent deterioration of their medical health. This includes a history of, but is not limited to: | | |
| Cardiovascular:   * + - heart failure     - cardiac arrhythmia’s     - myocardial infarction within the last 12 months     - stable angina     - uncontrolled hypertension | | |
| Respiratory:   * + - smoking related airway disease - severe COPD (FEV1 <50% predicted), very severe COPD (FEV1 <30% predicted), or ≥2 exacerbations per year, or one or more requiring hospitalisation     - haemoptysis not investigated | | |
| Gastrointestinal:   * + - known alcohol related liver disease at risk of decompensation (e.g. known varices, stable ascites, stable jaundice, coagulopathy e.g. INR >1.4)     - BMI <18.5 with unintentional weight loss (≥5% body weight in 6 months) or malnutrition     - risk of refeeding syndrome     - severe vomiting and diarrhoea | | |
| Renal:   * + - chronic renal failure (eGFR < 45 ml/min, Stage 3b to Stage 5) | | |
| Neurological:   * + - recent stroke within 12 months     - significant cerebellar ataxia and unable to mobilise independently     - falls resulting in head injury with intracranial bleed within the last 12 months     - frequent seizures due to epilepsy | | |
| Endocrine   * + - poorly controlled diabetes mellitus     - electrolyte imbalance e.g. severe hyponatraemia (serum sodium <125mmol/L) | | |
| Oncology   * + - suspected cancer or known cancer requiring treatment | | |
| Infection   * + - known HIV or Hepatitis C not receiving treatment     - injection site abscess or related limb swelling that may indicated thrombosis or an infected thrombosis | | |
| **18. Exclusion criteria** | | |
| The predominate reason for exclusion to the ACCS will be: | | |
| 1. No evidence of engagement in the assessment or care planning process towards detoxification by community substance misuse teams event at referral | | |
| 1. No aftercare plan or appropriate step down accommodation in place for the service user | | |
| 1. Excessive risk of violence and aggression based on a community substance misuse risk assessment based on a Trusted Assessor approach | | |
| **Individuals may be re-referred to the ACCS if the reasons for a previously rejected referral have been mitigated via the local authority or community substance misuse team.** | | |