



DASL Ref:

Tower Hamlets Community Alcohol Team Brief Intervention/Initial Contact
ALL SECTIONS MUST BE FULLY COMPLETED

1. Service User's Information

First Name						
Middle Name(s)						
Surname						
Address						
	Postcode:					
Borough		Permission to Call?		Permission to leave message?		
Permission to send letter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes	No	Yes	No
Home Telephone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Work Telephone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobile		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Date of Birth (dd/mm/yy):		Gender : Male <input type="checkbox"/> Female <input type="checkbox"/>				
Has client consented to referral? Yes <input type="checkbox"/> No <input type="checkbox"/>						

1.2 Referrer's Details

Today's Date (dd/mm/yy)	
Organisation <i>(if referred in from outside DASL)</i>	
Staff name	
Contact tel. number	
Contact fax number	
Contact Address	

2.0 Client's Ethnicity *(not to be entered into MIDAS from this form)*

Nationality (at birth):

Ethnicity (tick one):

- | | |
|---|---|
| British (English, Scottish, Welsh) <input type="checkbox"/> | Pakistani or British Pakistani <input type="checkbox"/> |
| Irish <input type="checkbox"/> | Bangladeshi or British Bangladeshi <input type="checkbox"/> |
| Other White <input type="checkbox"/> | Other Asian <input type="checkbox"/> |
| White and Black Caribbean <input type="checkbox"/> | Caribbean <input type="checkbox"/> |
| White and Black African <input type="checkbox"/> | African <input type="checkbox"/> |
| White & Asian <input type="checkbox"/> | Other Black <input type="checkbox"/> |
| Other Mixed <input type="checkbox"/> | Chinese <input type="checkbox"/> |
| Indian or British Indian <input type="checkbox"/> | Any Other <input type="checkbox"/> |
| Not Stated <input type="checkbox"/> | |

3.0 Who has the Alcohol Problem? *(please tick one)*

- | | | |
|----------------------------------|----------------------------------|--|
| Client <input type="checkbox"/> | Sibling <input type="checkbox"/> | Other Relative <input type="checkbox"/> |
| Partner <input type="checkbox"/> | Child <input type="checkbox"/> | Other <input type="checkbox"/> |
| Parent <input type="checkbox"/> | Friend <input type="checkbox"/> | Previous Client <input type="checkbox"/> |

4.0 Current Substance Use:

Alcohol Use *(please include an average number of units consumed per week):*

.....units per week

Drug Use:

7.0 Additional Information

Mental health;

Physical health;

Suicide/self harm;

Legal;

Pregnancy;

Interpreter required?

8.0

Worker's Name:

Signature:

Return by fax to: 020 7702 2227
Or by post to: 2nd Floor North, 100 Christian Street, Whitechapel, E1 1RS