REFERRAL TO ADDICTION RECOVERY SERVICE

The Living Room Hertfordshire
8-10 The Glebe
Chells Way
Stevenage
Hertfordshire
SG2 0DJ

01438 355649
enquiries@thelivingroom.me.uk
www.livingroomherts.org

CONFIDENTIAL ONCE COMPLETED

Professional Information:	
Organisation Name:	
Name of Referrer:	
Email Address:	
Contact Number:	
Client Information BLOCK CAPITALS PLEASE	
Name of Person:	
Date of Birth:	
Address:	
Town:	
County:	
Postcode:	
Email Address:	
Contact Number:	
Reasons for Referral:	
Background and Relevant History:	
Medication: (CGL - Please state if you are going to be prescribing for this client and therefore completing TOP forms at Tier 3)	

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Special Access Needs or Disability:	

Have you obtained consent for this referral, from the client?

Yes ☐ No ☐

FURTHER DETAILS: