

**Cover Sheet for Regional Inpatient detox application**

**Treatment Required:**

**Medically Managed Inpatient Detox**

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| **Date application submitted:** |  | | |
| **Name of client: (Title, first and last name)** |  | | |
| **Date of birth & age of client:** |  | | |
| **Gender:** |  | | |
| **Ethnicity of Service User:** |  | | |
| **Substance: (Drugs, Alcohol or both)** |  | | |
| **Date of previous detox / residential episodes:**  **(If applicable)** |  | | |
| **Name of referring service:** |  | | |
| **Date of first assessment by referring service:** |  | | |
| **Name of Worker:** |  | | |
| **Name and address of residential unit/s:** |  | | |
| **Proposed admission date:** |  |  |  |

**Detox Criteria (please ensure criteria applies)**

**Essential Detox Criteria:**

**All Applications for Detox should include:-**

* Recent blood Test Result (within the last 6 weeks).
* Personal statement outlining the motivation for change
* A Clear aftercare plan
* Contingency plan in place if aftercare not successful
* Clear specific reason home detox is not appropriate for the service user

**And:-**

**Alcohol Detox Specific Criteria**

* Evidence of reduction in consumption or conversion to lower strength alcohol
* Explanation as to why they cannot reduce or reduce further
* Evidence of dependence (CIWA-ar) and breathalysed

(Nice Clinical Guideline recommends medically assisted detox for those drinking over 15 units daily)

* Engagement with Prep for Change or equivalent (1:1 or groups) within the last 4 weeks of the application.
* Explanation of previous relapses following detoxes

**Opiate Detox Specific Criteria**

* Evidence of reduction in illicit drug use
* Stability on opiate substitute medication, reducing if possible

Those reducing would expect to be illicit opiate drug free.

* Dates of drugs screens undertaken within the past 12 weeks evidencing some clean drug screens
* Engaging in psychosocial treatment other than their OST clinic attendance.

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|  | **Please tick:** | |
| **The client does meet all of the above criteria** |  | |
| **The client does not meet all of the above criteria (If not, please state below)** |  | |
|  | | |
| **Do you give consent to share client information with the Essex Treatment System?** | |  |

**Please send your completed cover sheet, together with a completed application form, to**: [**epunft.alcohol@nhs.net**](mailto:epunft.alcohol@nhs.net)