

**Health and Substance Misuse Referral Form**

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| --- | --- |
| Referrer’s Name and Organisation |  |
| Contact Number |  | Date |  |
| Where did you hear about us? |  | Self/Parental/Carer only:Did an agency ask you to refer? If so which agency? |  |

**Young Persons Details:**

|  |  |  |
| --- | --- | --- |
| Name:  | Date of Birth:  | Age:  |
| Ethnicity:  | Religion:  | Gender:  | Language:  |
| Address: | Contact Numbers:  |
| Consent to send letters home: Yes/No | Consent to text: Yes/No |
| With whom do they live: |  |
| Are parents/carers aware of the issues: YES/NO | If appropriate Parent/Carers details: |
| Is their accommodation: *Please give reasons* | Suitable | Unsuitable |
| Is there a housing issue: | Yes | No |
| Preferred contact method:  |  |
| Dates and times available: |  |
| Education or Employment Venue: |  |
| Number of ETE hours per week: |  |
| Has the young person given consent for this referral?  | YES*Required* | NO |
| Have the parents/carers been informed of this referral? |  YES*Required for under 13yrs* | NO |

**Other agency involvement:**

|  |  |  |  |
| --- | --- | --- | --- |
| Children’s Social Care involvement Yes/NoSocial worker: | Child In Need | Child Protection Plan | Child Looked After/Care Leaver |
| Other Professional | Service | Role | Contact details |
|  |  |  |  |
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**Please select the Referral Reason:**

|  |  |  |  |
| --- | --- | --- | --- |
| External Referral |  | Internal Referral (YOS Only) |  |
| * Drug and Alcohol Concerns (*Required)*
 |  | * General Health
 |  |
| * Smoking Cessation
 |  | * Mental Health
 |  |
| * Mental Health Concerns
 |  | * Substance Misuse
 |  |
| * Sexual Health Concerns/Support
 |  |  |  |
| * Offending Behaviour
 |  |  |  |
| * Child Protection Concerns
 |  |  |  |
| * Sexual/Criminal Exploitation Concerns
 |  |  |  |
| * Other (please state):
 |  |  |  |
| * School Inclusion SAS Intervention
 |  |  |  |
| * Youth Alcohol Drug Diversion (YADD) (Police Only)
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| **Summary of problems/concerns** *(including drug and alcohol use/mental health/physical health/disability/social circumstance and why the young person wants to be referred)* |
| *(Not required if YADD attached)* |
| **Summary of risk** |
| *(Not required if YADD attached)* |
| **Any other relevant information**  |
| *(Not required if YADD attached)* |
| **Is the YP engaged in any therapy or counselling Y/N**If yes, please detail below. |
| *(Not required if YADD attached)* |
| **Requirements of order** *(YOS Only)* |
| *(Not required if YADD attached)* |

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| **Please return the completed form to:** |
| FAO SAS Young People’s Substance Advice Service, YOS, 24-26 Walliscote Road, WSM, BS23 1UPTel: 01275 888360, Fax: 01275 888361 **Email:** **sas@n-somerset.gov.uk****Please do not send referrals to practitioners email addresses.** |