

**Health and Substance Misuse Referral Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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/No  Social 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 1UP  Tel: 01275 888360, Fax: 01275 888361  **Email:** [**sas@n-somerset.gov.uk**](mailto:sas@n-somerset.gov.uk)  **Please do not send referrals to practitioners email addresses.** |