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|  |  **Young Person’s Substance Misuse Service** **DRUG / ALCOHOL REFERRAL FORM** Fields with \* MUST be Completed Please |
| **1** | **Essential Criteria for Acceptance of Referral: (if you answer ‘No’ to any of the questions in Box 1, please contact us to discuss further)****\*Is the young person aware of this referral? Yes € No € & \*Do they agree to this referral? Yes € No €** |
| **2** | **\*Are the young person’s parents/carers aware of this referral? Yes € No €****(please note: the parental consent form is required for a young person under the age of 13 years)** |
| **3** | Do you feel this young person would benefit from an initial ‘Introduction session’ to learn more about the service we offerand how we can support them? Yes **€** No **€**  |
| **4** | Referrers Name: | Organisation: | Role: |
| Address: |
| Contact Tel No: | E Mail Address: | Person to contact in your absence: |
| **5** | Client Name: Address: Postcode: Contact Tel No: Date of Birth: Age: Gender: Ethnicity: Parent/Carer Name & Tel No:\*Can the young person be contacted at home? Yes € No € \*Are there any risks in visiting the home? Yes € No € Please record detail of risks: | Client’s Education Status:Name of school / college: |  |
| Is the young person receiving mental health treatment? Yes **€** No **€**Professional working with client: |
| Does the young person have learning / Disability needs?Please provide details: |
| GP Name/Surgery  |
| Do The young person’s parents use substances?Yes **€** No **€**Please provide details: |
| **6** | SUBSTANCE USE (Drug and alcohol) |
| Substances used | Route e.g. smoke | How much e.g. £, bags, cans, bottles | How often e.g. daily, 2/7, weekly, binge |
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| **7** | \*SAFEGUARDING |
| **Are there any Safeguarding concerns?** Yes **€** No **€ Is the young person on a Child Protection Plan?** Yes **€** No **€****Is the young person on a Child In Need Plan?** Yes **€** No **€ Is the young person a Looked After Child?** Yes **€** No **€** Social Workers name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Please detail reason for involvement or Safeguarding concerns:**  |
| **8** | \*EXPLOITATION – CSE /CCE |
| **Has a Risk Factor Matrix been completed?** Yes **€** No **€ Is the young person on MACE panel?** Yes **€** No **€** **Risk level on Matrix** Low **€** Medium **€** High € CCE € CSE € DUAL € **Please detail reasons for Matrix being completed:**  |
| **9** | OFFENDING |
| Is the young person involved in criminal activity Yes **€** No **€** Is the young person at risk of becoming involved in criminal activity Yes **€** No **€** Is the young person working with the Youth Offending Service Yes **€** No **€ Case Manager’s Name:****Please detail offence type/s, & additional information:**  |
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| **\*STRENGTHS AND PROTECTIVE FACTORS\*** |
| Please record what strengths the young person has and the protective factors in place:  |
| **\*ADDITIONAL INFORMATION\*****Identified Risks:** **Safeguarding, Risks to home visiting, Risk to worker, Exploitation, overdose, offending, physical/mental health issues, binge use, & Any Other Relevant Information** |
| Please record any extra information to support the referral:Is an Interpreter required? Yes **€** No **€** If so, for which language? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **Please submit your referral:****By Post** - Suite 1, 7-8 Mill Street, Stafford. ST16 2AJ. **Tel:** 01785 241393 **E mail:** t3stars.stafford@humankindcharity.org.uk |

March 2023