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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 offer  and 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 | |
|  | |  | | |  | |  | |
| **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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Continued……….

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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? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| **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](mailto:t3stars.stafford@humankindcharity.org.uk) |

March 2023