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|  |  **Young Person’s Substance Misuse Service** **HIDDEN HARM 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:  Contact number for Parent/Carer (if appropriate):\*Can the young person be contacted at home? Yes € No €\*Who does the Young Person live with?   \*Where would be the best venue to meet the Young Person?\*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 client receiving mental health treatment? Yes **€** No **€**Professional working with client: |
| Does the client have learning / Disability needs?Please provide details: |
| Is the young person engaging in Offending Behaviour?Yes **€** No **€**Please provide details |
| Is the young person at risk of Exploitation?Yes **€** No **€**CSE € CCE € DUAL €Has a Risk Factor Matrix been completed? Yes **€** No **€**Risk level on MatrixLow **€** Medium **€** High **€** Please provide details: |
| **6** | FAMILY / CARER SUBSTANCE USE (Drug and alcohol) |
| **Is the young person aware of the substance use within the family?** | **Name of parent / family member using substances** | **Substances being used** | **What is the impact of the substance use on young person?****What knowledge does the young person have around the substance use?** |
| **YES € NO €****Referrals will only be considered if the young person is aware of the substance use.** |  |  |  |
| **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:**  |
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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, injecting, 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 |