Referral form for YP’s aged under 18 and 19-25

Please send the completed form to: [**ypreferrals@sotcdas.org.uk**](mailto:ypreferrals@sotcdas.org.uk)

| **Date of referral:** |
| --- |
| **I am making a referral for a young person aged:**   * 18 and under * 19-25 |

| **Client’s Details** | |
| --- | --- |
| **Name**: | **Contact number:** |
| **Address:**  **Postcode**:  **Living situation** (e.g. living with parents/supported housing)**:** | **DOB**: |
| **Ethnicity**: |
| **Gender**:   * Male * Female * Non-binary * Prefer not to say |
| **Has the client consented to the referral?**  ☐ Yes ☐ No | |
| **Are there any known risks at the Client’s address:** | |
| **GP details:** | **Next of kin/emergency contact**:  **Relationship:**  **Contact number**: |
| **Is there anything that would help make our services more comfortable or accessible for the client?** |

| **Referrer Details** | |
| --- | --- |
| **Name of referrer:** | **Position / Title:** |
| **Organisation:** | **Contact number:**  **Email:** |
| **Relationship to Client:** |

| **Please note any vulnerabilities or exploitation risks we should be aware of to ensure appropriate safeguarding:** | **Are there any family circumstances related to substance use that might be relevant to the young person's care needs?** |
| --- | --- |
| **Any other risks known:** | |

| **Please indicate why you are making the referral?** |
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|  |

| **Drug and/or alcohol use:** (please list all substances) | | | |
| --- | --- | --- | --- |
| **Drug** | **Route** | **Frequency** | **Amount** |
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| **Additional Information** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Other services involved:** (please tick) | | | | | |
| * Social Worker * CAMHS * YOT * STAR/Base 58 * Early Help * Youth Worker * Doctor / Nurse * Education * Care Worker | | | | | |
| Please provide details of all professionals involved: | | | | | |

| **For office use only** |
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| Referral taken by: |

