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

Please send the completed form to: **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** |
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| **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** |
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| **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) |
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| **Drug** | **Route** | **Frequency** | **Amount** |
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| **Additional Information** |
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| **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: |

