|  |  |
| --- | --- |
| Date referral  |  |

Client Details

|  |  |
| --- | --- |
| Does the young person consent to the referral? | [ ] Yes [ ]  No *- if no, please inform referrer that this consent needs to be sought before we are able to accept the referral.*  |
| Forename |  | Family Name |  |
| Nickname |  | Previous Family Name |  |
| Date of Birth |  | Age |  |
| If young person is under 13, parental consent is required. Does the parent consent for the young person to be referred to us? | [ ] Yes [ ]  No *- if no, please inform referrer that this consent needs to be sought before we are able to accept the referral.* |
| If young person is over 19, please give details around learning disability or vulnerability |  |
| Gender | [ ] Male [ ]  Female | Nationality |  |
| Preferred Language |  | Speaks English | [ ] Yes [ ]  No |
| Religious beliefs |  | Ethnicity |  |
| Disabilities |  |
| Address |  |
| Postcode |  |
| Contact Number |  | Contact Info *(i.e mums mobile, contact times)* |  |
| Alternative Contact Number |  | Alternative Contact Info |  |

Guardian Details

|  |  |
| --- | --- |
| Are parents / carers aware of this referral? | [ ]  Yes [ ]  No |
| If not, why? |  |
| Name of next of kin |  | Relationship |  |
| Contact number(s) |  |
| Contact Info *eg best time to call* |  |

Referrer Details

|  |  |
| --- | --- |
| Name of referrer |  |
| Name and address of organisation |  |
| Relationship to client |  |
| Mobile number |  | Phone number |  |
| Contact info *e.g. best time to call* |  |
| E-mail address  |  |  |  |
| How did you hear about our service? |  |

|  |  |  |
| --- | --- | --- |
| Is the client a parent/carer of young person using substances? | [ ] Yes [ ]  No |  |
| Reason for referral / General notes |
| * What happened to prompt referral?
* What are they using?
* How much/how often?
* How long have they been using?
* Ask about friends, family, positive and negative things.
* What are they worried about?
* What does yp think about their behaviour/drug use?
* What do parents think?
* What has happened so far for support?
* Mental health?
* Police? YOT?
* School/college support?
* What does yp hope to get from our service? YP views. (check yp has actually said why they want support)
* If appropriate, any cse/cce risk screening
* Any witnessing/experiencing domestic abuse/ ACE’s we should be aware of?
 |
| Substance\* | Frequency | Quantity | Route\* | Cost | Last used | Age first used\* | Prescribed |
| 1  |  |  |  |  |  |  |  |
| 2  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| Has the young person ever injected? | [ ]  Previously [ ]  Currently [ ]  Never [ ]  Client declined to answer |
| Has the young person injected the last 30 days? | [ ]  Yes [ ]  No |
| Any potential risks or concerns*If referrer has a risk assessment for client, request a copy* | Also any risks to worker doing home visit, is it recommended or are there other people there who aren’t safe?Any pets? (allergies, dog bites etc.) |
| Initial contact arrangements *e.g. will referrer set up first appointment, contact young person directly*   |  |

Multi Agency

|  |  |
| --- | --- |
| Is the family receiving any statutory interventions? | [ ]  Section 17 – Child in Need □ Section 47 – Child Protection [ ]  LAC[ ]  FSP [ ]  Other Children Services involvement [ ]  No [ ]  Not known |
| Lead Professional/Social Worker |  |
| Are there any other services involved with the family?  | Young Carers, YOT, education, Early help etc. |

Client GP details

|  |  |
| --- | --- |
| GP Surgery |  |
| Phone number |  |
| Address |  |

Please return referral form via email to: unity@matthewproject.org