**YOUNG PERSON’S SERVICE REFERRAL FORM**

**Please send the completed form to:** **referrals@sotcdas.org.uk** **or post to address below**

| **Date of referral:**  |
| --- |

| **Young person’s details:** |
| --- |
| Name:  | Contact number:  |
| Address: Type of accommodation:  | DOB:  |
| Ethnicity:  |
| Gender:  |
| Religion:  |
| Has the YP consented to the referral? Have the parents / carers been informed of the referral?  |
| Are there any known risks at the YP address |
| GP details: | Next of Kin /Emergency contact: Relationship:Contact number: |
| Medical conditions/ disabilities including Learning difficulties:  |

| **Referrer details:** |
| --- |
| Name of referrer:  | Position / Title: |
| Organisation: | Contact number: |
| Relationship to YP: |

| **Are there any CSE concerns?**  | **Hidden Harm: DV/MH/substance use in home**  |
| --- | --- |
| **Any other risks known**  |

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

|  **Drug / Alcohol use:** (please list all substances) |
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| **Drug** | **Route** | **Frequency** | **Amount** |
|  | Smoke  | Daily  | 3.5- 8th  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| **Additional Information** |
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| **Other services involved:** (please tick) |
| Social Worker  |  | STAR/Base 58 |  | Youth Worker |  |
| CAMHS |  | YOT |  | Doctor / Nurse |  |
| Early Help  |  | Care Worker |  | Education |  |
| Please provide details of all professionals involved:  |

| **For office use only:** |
| --- |
| Referral taken by: | Allocated to: |
| YP contacted on:  | First Appointment booked for:  |