**YOUNG PERSON’S SERVICE REFERRAL FORM**

**Please send the completed form to:** [**referrals@sotcdas.org.uk**](mailto: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?** |
| --- |
|  |

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

| **Additional Information** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **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: |