REFERRAL FORM

ALL OF THIS SECTION MUST BE COMPLETED IN FULL FOR US TO ACCEPT THE REFERRAL

First Name:	Last Name:	Age :	Date of Birth:	Gender (please tick): Male ☐ Female ☐	Nebula Number (office use only):

Address: House number/Name/Street/Area/Town

Postcode: **Consent to use this info to contact client?** Y ☐ N ☐

Living with Parents/Relatives ☐ | Living independently/Unsettled Accom ☐ | Child Looked After ☐

Living independently/Settled Accom ☐ | Living independently/NFA ☐ | YP Living in Secure Care ☐

YP Living in Care ☐ | Living in Supported Housing ☐

Home telephone:	Consent to use? Y ☐ N ☐	**Young Person's Ethnicity:**
Young person's mobile telephone:	Consent to use? Y ☐ N ☐	**Notes** (Please use additional sheet if needed):
Other Mobile Telephone	Consent to use? Y ☐ N ☐	
Email Address:	Consent to use? Y ☐ N ☐	

Main Substance: (*MUST be completed)

Substance 2:

Substance 3:

Does Parent/Guardian of YP know of this referral? YES ☐ NO ☐

Young Person's Current Status::
Please tick YES √ if known or leave blank if not known

MH treatment need identified	☐	Have a CAF/EHA	☐
In contact with YOT/YOS	☐	Currently Homeless	☐
Involved in Sexual Exploitation	☐	Young Carer	☐
Involved Self Harm	☐	Currently Pregnant	☐
Involved in unsafe drug use	☐	Looked after by LA	☐
Involved in Offending	☐	Engaged in unsafe sex	☐
In contact with Disability Services	☐		
With Drug/Alcohol using parents/carers	☐		

Referral Source: Please ensure ONE of these is ticked

CLA – Child Looked After	☐	GP	☐	Adult Treatment Provider	☐	Youth Offending Institute	☐	Website	☐
Children & Family Services	☐	A & E	☐	Young People's Treatment Provider	☐	Secure Training Centre	☐	Employer	☐
Universal Education	☐	Hospital	☐	Non Treatment Subs Misuse Service	☐	Secure Children's Home	☐		
Alternative Education	☐	Non Child Mental Health Service	☐	FRANK Helpline	☐	Post Custody	☐		
Targeted Youth Support	☐	Primary Care	☐	Self-referral via health professional	☐	Self	☐		
Outreach	☐	Children's Mental Health Service	☐	Crime Prevention	☐	Relative	☐		
YP Housing Provider	☐	School Nurse	☐	YOT/YOS	☐	Concerned Others	☐		

Young person's Education Status:
Please tick YES √ if known or leave blank if not known

Mainstream Education	☐	Regular Employment	☐
Alternative Education	☐	Unemployed and not seeking work	☐
Temporarily Excluded	☐		
Permanently Excluded	☐	Economically Inactive Caring Role	☐
Persistent Absentee	☐	Economically Inactive Health Issue	☐
Apprenticeship/Training	☐	Voluntary Work	☐

Referrer Contact Details: NAME/ADDRESS/E-MAIL	**Violence Risk/Risk to EB Worker or Others:** (Low/Medium/High) (Risk to Peers/Family Workers etc)	**Is a SOCIAL WORKER involved?** YES ☐ NO ☐
		If not involved, has a CAF been completed? YES ☐ NO ☐
Signature of Referrer:	**Date Referral sent to Early Break:**	**Name/information of Social Worker/Lead Professional:**