REFERRAL FORM

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

First Name:	Last Name:	Pronoun:	Age:	Date of Birth: / /	Gender	Is the YP trans? Yes/No/Prefer not to say/Not Known Please use notes section if necessary	Database 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/Settled Accom ☐
YP Living in Care ☐
Living independently/Unsettled Accom ☐
Living independently/NFA ☐
Living in Supported Housing ☐
Child Looked After ☐
YP Living in Secure Care ☐

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 √ of NO X or 'NOT LNOWN' - leave blank

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 √ of NO X or 'NOT KNOWN' - leave blank

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: