**Referral Form**

*(To be completed by the referring agency)*

Referral for young persons: Own substance use Parent/sibling substance use

Is the client aware of and consented to the referral:  Yes No

Is the parent/carer aware of this referral: Yes No

Next of Kin name/contact number: Click here to enter text.

Consent to contact next of kin: Click here to enter text.  Yes No  
Date Consent gained: Click here to enter text.

What does the young person want to achieve from engaging in the service?: Click here to enter text.

Young Persons Details

Name: Click here to enter text.  
DOB: Click here to enter text.   
Address: Click here to enter text.

Click here to enter text.

Post Code: Click here to enter text.  
Contact number: Click here to enter text.

Gender: Click here to enter text.

Ethnicity: Click here to enter text.

Religion: Click here to enter text.

GP Details: Click here to enter text.

Referrer Details

Referrer: Click here to enter text.

Role/job title: Click here to enter text.

Referring agency name and address: Click here to enter text.

Click here to enter text.

Post Code: Click here to enter text.

Office telephone number: Click here to enter text.

Mobile telephone number: Click here to enter text.

Email address: Click here to enter text.

For the young person to complete (where possible)

Do you use drugs or alcohol: Yes No

Does a member of your family use drugs or alcohol: Yes  No

What substance do you/they use: Click here to enter text.

Route of use (smoke, sniff etc.): Click here to enter text.

Amount (money, bags, cans, bottles etc.): Click here to enter text.

Frequency of use (daily, twice a week, weekly, binge etc.): Click here to enter text.

Who do you live with: Click here to enter text.

Are you currently involved in:  Education Training Employment  NEET

Provider/School Details: Click here to enter text.

Are you or have you been sexually active:  Yes  No

Young person or partner currently pregnant:  Yes  No  Unsure

Parental status: Click here to enter text.

Additional specific needs or requirements (learning difficulties, emotional/mental health, behavioural, family issues etc.): Click here to enter text.

Are there any Safeguarding issues or identified risks (lone working, home visits etc.) or any other relevant information: Click here to enter text.

Does the young person have:  EHA  CIN  CP  LAC  MASE  TAF

Details: Click here to enter text.

Date of next meeting: Click here to enter text.

Physical health concerns/diagnosis: Click here to enter text.

Mental health concerns/diagnosis: Click here to enter text.

Relevant medical history: Click here to enter text.

Have they been arrested in the last six months:  Yes  No

Are they currently or at risk of becoming involved in criminal activity:  Yes  No

If yes, please give details: Click here to enter text.

Consent for sharing information with the young person:  Yes  No

Any other professionals involved: Click here to enter text.

Once completed please return to :

Post: **Wolverhampton 360**

**Recovery Near You**

**5-9 Pitt Street**

**Wolverhampton**

**WV3 0NF**

Secure Email: [bsmhft.recoverynearyou@nhs.net](mailto:bsmhft.recoverynearyou@nhs.net)

Telephone : **0300 123 3360**

**FOR OFFICE USE ONLY**

Date allocated: Click here to enter text.

AQClick here to enter text.

Key Worker: Click here to enter text.

1st Appointment offered: Click here to enter text.