

**Young People and Family Service**

**Drug and Alcohol Services for Young People under 18 including Specialist Family Support for Children and Adults.**

**‘Putting the pieces together’**

**REFERRAL FORM – PLEASE COMPLETE THIS FORM AND EMAIL IT TO:** [**jigsaw@cgl.org.uk**](mailto:jigsaw@cgl.org.uk)

**PLEASE ENSURE ALL SECTIONS OF THIS FORM ARE COMPLETED - IF ALL SECTIONS ARE NOT COMPLETED THE REFERRAL WILL NOT BE ACCEPTED.**

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| **REFERRER’S DETAILS** | |
| Date of Referral: | |
| Who is this referral for: | Young Persons treatment?  Family support? |
| Referrer’s Name: | Position: |
| Agency Name & Dept.: | Referrer’s Address: |
| Contact Telephone Number: | Email: |

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| **DETAILS OF PERSON BEING REFFERED** | |
| Name: | Date of Birth: |
| Address: | Post code: |
| Telephone number: |
| Gender at birth: Male  Female  Unknown | |
|  | |
| Safeguarding status: |  |
| Name of Social Worker/PF Lead: | Date of next multi agency meeting: |
| Disability/Special Needs: | Language Needs: |
| School/ College Name and Address (YP only): | Name and contact of School Lead: |

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| **FAMILY DETAILS**  Please provide details of all Children, Young People and Adults within the family home: | | | | | |
| **Name:** | **Gender:** | **Relationship:** | **DOB:** | **Ethnicity:** | **Is support needed?** |
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| **ETHNICITY** | | | | | |
| White British |  | White Irish |  | White Other |  |
| White/Black Caribbean |  | White Black African |  | White/Asian |  |
| Bangladeshi |  | Pakistani |  | Indian |  |
| Black African |  | Black Caribbean |  | Black British |  |
| Mixed Other |  | Asian Other |  | Black Other |  |
| Chinese |  | Vietnamese |  | Somali |  |
| Other (please specify): |  | | | | |

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| **SUBSTANCE** | | | | | | |
| Alcohol | |  | Amphetamine |  | Benzodiazepines |  |
| Cannabis | |  | GHB |  | LSD/Poppers |  |
| Cocaine | |  | Magic Mushrooms |  | Solvents |  |
| Heroin | |  | Methadone |  | Novel Psychoactive Substance |  |
| Ecstasy | |  | Ketamine |  | Tobacco |  |
| Crack Cocaine | |  | Steroids |  | Unknown |  |
| Other (please specify): | | | | | | |
| If abstinent please state approximate time: | | | | | | |
| Is substance user injecting? | Yes  No | | | | | |
| Who is the substance user? (please include full name and relationship to client?) | | | | | | |
| **REASON FOR REFERRAL (use next page for more space)** | | | | | | |

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| **METHOD OF CONTACT AND CONSENT** | | | | | |
| Does the person give consent to this referral and to enter their information onto our Database? | | | | YES  NO | |
| Where does the person wish to be seen? | | | | | |
| Preferred method of contact: | | | | | |
| Letter | Text | Telephone Call | Via referrer | | Other: |

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| **OTHER AGENCY INVOLVEMENT**  Pease list the names of the agencies and contact below if referral is receiving any holistic support | | |
| **Name of Agency** | **Name of Keyworker/Lead Person** | **Contact Information** |
| YOT |  |  |
| Community Mental Health |  |  |
| Social Service (Adult, Children, Families) |  |  |
| GP |  |  |
| Other: |  |  |
| Other: |  |  |

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| **RISK/ADDITIONAL INFORMATION** | | |
| ***Are there any significant risks which the service should be aware of?*** |  |  |
| **Physical and mental health** | **Yes** | **No** |
| Physical health problems/diagnosis |  |  |
| Is on medication |  |  |
| Current/previous MH/LD |  |  |
| Current/previous self-harming behaviour |  |  |
| Previous suicide attempts or current ideation |  |  |
| **Risk in relation to others** | **Yes** | **No** |
| Risk of physical, emotional, financial or others |  |  |
| Other abuse from others |  |  |
| Currently/previously physically violent towards others |  |  |
| Physically, emotionally, financial or other abuse towards others |  |  |
| **Safeguarding children** | **Yes** | **No** |
| Has Children under 18 years of age |  |  |
| Is pregnant |  |  |
| Has part/full time child care responsibility for own or another person’s child |  |  |
| Has contact with children through partner, family or others |  |  |
| Case open/contact with social services regarding Safeguarding children issues |  |  |
| **Housing/Finance/Other** | **Yes** | **No** |
| NFA/Rough Sleeper/Accommodation Unstable |  |  |
| Debt or financial problems |  |  |
| Other risk |  |  |
| Naloxone training needed |  |  |
| If yes to any of the above please provide further information below around the details and nature of risk:  **(This is to ensure that staff are kept safe and will provide additional information to assist the allocation process to ensure client is receiving the best support possible.)** | | |

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| For individuals under 13 year’s old, person with parental responsibility (parent, guardian, carer, social worker, etc.) to complete below: | |
| Name of child/children: | Relationship to child: |
|  |  |
|  |  |
| Print name of person with Parental Responsibility: | |
| Sign name of person with Parental Responsibility | |
| Date: | |
|  | |
| **THERE IS A REQUIREMENT FOR THE REFERRER TO BE AVAILABLE AND MAINTAIN CONTACT WITH CGL THROUGHOUT THE TREATMENT EPISODE AND MAY BE REQUIRED TO ATTEND AN UPDATE SESSION WITH THE CLIENT OR ASSIST IN MAKING CONTACT WITH THE CLIENT** | |

PLEASE RETURN THE COMPLETED REFERRAL FORM TO:

**CGL Jigsaw Young People and Family Service**

**2 Russell Place, Nottingham, NG1 5HJ**

**Email:** [**jigsaw@cgl.org.uk**](mailto:jigsaw@cgl.org.uk) **or referrals can be taken over the phone on 0115 948 4314**