**Referral Form – Please ring 01773 303646 to make a referral or return to:** **derbyshire@cgl.org.uk**

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| --- | --- | --- | --- |
| **Has the young person agreed to the referral?**  | **Yes ¨ No ¨****NB – we only accept a referral when a young person has given consent**  | **Date of referral:**  |  |
| **Name:** |  |
| **Date of Birth :**  |  | **Age :** |  |
| **Ethnicity:**  |  | **Gender :**  |  |
| **Address:****Postcode:** |  |
| **Contact Number: Home –**  **Mobile –** |  |
| **Can we phone?**  | **Yes ¨ No ¨**  | **Can we write?** | **Yes ¨ No ¨**  |
| **Brief details of substance use:** |  |
| **Are there any Vulnerabilities / concerns**Such as: Offending Behaviour, Parental Use, Homelessness, NEET, IV drug use, overdosing, young parent, immigrant |  |
| **Other agencies involved****Name & Contact details** |  |
| **Are Social Care involved****Name of social worker****Contact Number**  | **Yes ¨ No ¨ If yes please indicate below****LAC ¨ CIN ¨ CP¨** |
| **Are there any safeguarding / CSE concerns**  | **Yes ¨ No ¨ If yes please give details below** |
| **Have you completed a screening toolkit**  | **Yes** **¨ No** ¨ If yes can you send us a copy |
| **Any health concerns or disabilities?**Physical or mental health |  |
| **Referral to DrugFAM?** |  |
| **Are parents/guardians aware of the referral?** **Name of parent/carer** **Contact Number****Can we contact the parents / guardians?** | **Yes ¨ No ¨ Not known ¨****Yes ¨ No ¨ Not known ¨** |
| **Referrer’s details****Name****Address****Telephone Number****E-mail address** |  |
| **Where would the young person like to be seen?****If a home visit is requested are there any risks / concerns known at the home address?****Who is the appointment to be made with?** | **School ¨****Home Visit** **¨****Other ¨ (please state )****Yes ¨ No ¨ If yes please give details****Client ¨ Referrer ¨ Other ¨ please state:** |