

*Referral Form – Please return to:* [***derbyshire@cgl.org.uk***](mailto:derbyshire@cgl.org.uk)

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| --- | --- | --- | --- | --- | --- |
| **Has the young person agreed to the referral?** | **Yes No**  **Please note – we are only able to work with young people who consent to a referral.** | | **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:**  *E.g. offending behaviour, parental use, homelessness, NEET, injecting drug use, overdose, young parent, immigration.* |  | | | | |
| **Other agencies involved**  **Name & contact details** |  | | | | |
| **Are Social Care involved**  **Social Work Name**  **Contact Number** | **Yes No**  **If yes, please indicate below LAC/CIN/CP** | | | | |
| **Are there any safeguarding concerns?**  *E.g. CSE.* | **Yes No**  **If yes please give details below** | | | | |
| **Have you completed a screening toolkit?** | **Yes**  **No**   **Please attach with referral** | | | | |
| **Any health concerns or disabilities?**  *E.g. physical/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** |  | | | | |
| **What would the young person like & where would the young person like to be seen?** |  | | | | |

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