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**Drug and Alcohol Services for People Under 25 &**

**Specialist Impact Support for Children, Young People and Young Adults.**

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

***PLEASE ESURE 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: | |
| Referrer’s Name: | Position: |
| Agency Name & Dept.: | Referrer’s Address: |
| Contact Telephone Number: | Email: |
| Person contact to make first appointment: | Contact number: |

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| **DETAILS OF PERSON BEING REFFERED** | |
| Referral’s Name:  Date Of Birth: | Young Persons treatment u18?  Young Adult 18-25?  Impacted Support (Hidden Harm)? |
| 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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| **If support needed is marked ‘Yes’, please complete another referral form.** | | | | | |

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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 USED OR SUBSTANCE IMPACTED BY** | | | | | | |
| 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 | | | | | |
| **Please give as much detail as possible in the space below. More information we have, the easier it is for staff to prepare appropriate support.** | | | | | | |
| **REASON FOR REFERRAL**  Who is the best person to contact to make the first appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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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?  ***\*Please be aware that if consent has not been given this will delay the referral process and we may be unable to accept the referral.*** | | | | 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 |  |  |
| Parental/carer substance misuse |  |  |
| **Safeguarding children** | **Yes** | **No** |
| Has Children under 18 years of age |  |  |
| Is pregnant |  |  |
| Has part/full time childcare 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 and protection 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 years old, person with parental responsibility (parent, guardian, carer, social worker, etc.) to complete below: | |
| Name of child/children: | Relationship to child: |
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|  |  |
| 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 The Place - Drug & Alcohol and Impacted by substance service for U25’s**

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

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