**Breakout Referral Form**

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| **Young Person’s Name:** | | | | **DOB:** | | | | **Gender:** |
| **Address:**  **Postcode:** | | | | | **Young person’s Contact Number:** | | | |
| **Parent / Carers Name:** | | | | | **Contact Number:** | | | |
| **Language spoken:** | **Interpreter required:**  **Yes / No** | | | | **Ethnicity:** | | | |
| **School/Educational Provider:** | | | | | | | | |
| **Young person consented to referral?**  **Yes/No** | **Can the young person be contacted at home?** | | | | | | | |
| **Please give us some narrative behind the referral and any other information you feel is relevant?** | | | | | | | | |
| **What goal would the young person like to achieve? Eg Education/Support to reduce/Support to stop** | | | | | | | | |
| **We don’t need parental/carer consent (although we prefer it)**  **Parent / Carer consent to referral? Yes / No**  **If No – Please state reason why?** | | | | | | | | |
| **What other significant professionals have or are currently involved with the young person** (e.g., CAMHS, Paediatrician, School Services, Social care etc.) | | | | | | | | |
| **Organisation** | | **Name of Allocated worker** | | | | **Contact Details** | | |
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| **Name of referrer:**  **Role:** | | | **Contact number:** | | | | **Date of referral:** | |

**Drugs and Alcohol information**

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| **Drugs/Alcohol used** | **Route (please circle)** | **Frequency (please circle)** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |
|  | **Snort, smoke, oral, inject** | **Daily, weekly, monthly, occasionally** |