**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** |