**Via - West Berkshire Young People’s Drug and Alcohol Service: Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is the parent/carer aware of/in agreement with the referral? | | | | | | | | | | Yes | |  | | | No | |  |
| Is the young person aware of/in agreement with the referral? | | | | | | | | | | Yes | |  | | | No | |  |
| If no, please explain why in ‘Reason for referral’ below | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | |
| **Young Person’s Details- Contact details must be provided.** | | | | | | | | **Referrer’s Details** | | | | | | | | | |
| YP Name |  | | | | | | | Name of referrer |  | | | | | | | | |
| Age |  | DOB |  | | | | | Date of referral |  | | | | | | | | |
| Address |  | | | | | | | Referrer’s agency |  | | | | | | | | |
| Referrer’s contact details: |  | | | | | | | | |
| Postcode |  | | | | | | |
| Telephone |  | | | | | | | Child protection concerns, inc. abusive, violent relationships? | | | | Yes | |  | | No |  |
| Mobile |  | | | | | | | If yes, please give details (inc. lead agency/name of worker): | | | | | | | | | |
| Email |  | | | | | | |
| Preferred method of contact |  | | | | | | |
| Gender |  | Ethnicity | | |  | | | Would this young person pose any significant risk to staff or others? | | | | Yes | |  | | No |  |
| Nationality | |  | | | | | | If yes, please give details: | | | | | | | | | |
| Language spoken | |  | | | | | |
| NI No. (if known) | |  | | | | | |
| Attending school? | | Yes | |  | | No |  |
| If yes, name of school? | |  | | | | | | Is there a CAF? | | | Yes | |  | | | No |  |
| NHS No. | | |  | | | | | | |
| **Other agencies involved** | | | | | | | | **Name and address of GP** | | | | | | | | | |
| Name/agency: | | Tel number: | | | | | |  | | | | | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |
| **Reason for referral** | | | | | | | | | | | | | | | | | |
| *Concerns, drug use, motivation, any risk factors, mental health issues, emotional difficulties…* | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk Screen** | | | | | |
| Pregnancy |  | A parent |  | Injecting Drug Use |  |
| High risk sexual behaviour |  | Involved in gang activity |  | Suicide Risk |  |
| Mental Health Concerns |  | Vulnerable to abuse or exploitation |  | Involvement with the CJS |  |
| Homelessness |  | Involved with social care services |  | Other  (please specify below) |  |
| Please provide further details: | | | | | |

**Please return via email:**

**Email:** [TheEdge@viaorg.uk](mailto:TheEdge@viaorg.uk)

**Secure email:** [the.edge@wdp.cjsm.net](mailto:the.edge@wdp.cjsm.net)

**For any queries please contact us on:**

**Tel:** 01635 582002

**For Internal use only**

Date referral received: ………………………………………………………………

Referral received by: …………………………………………………………….

Case ID No.: ……………………………………………………………………………….