**REFERRAL YOUTH DRUG & ALCOHOL SERVICE**

**PLEASE ATTACH THE LATEST WELLBEING ASSESSMENT**

**CONSENT FROM YP FOR REFERRAL TO BE MADE: YES/NO**

**DATE OF REFERRAL:**

|  |  |  |  |
| --- | --- | --- | --- |
| TYPE OF REFERRAL(Please tick) | DRUG | ALCOHOL | DRUG & ALCOHOL |
|  |  |  |  |

|  |  |
| --- | --- |
| REFERRER DETAILS |  |
| NAME |  |
| ADDRESS |  |
| CONTACT NO |  |
| RELATIONSHIP TO YP: |  |

|  |  |
| --- | --- |
| YOUNG PERSON’S DETAILS | PARENT/CARERS DETAILS |
| NAME: | NAME: |
| ADDRESS: | ADDRESS: |
| CONTACT NO: | CONTACT NO: |
| DOB: | ARE PARENTS AWARE OF REFERRAL: Y/N |
| LEGAL STAUS: |
| DISABILITY: |
| GENDER RECOGNITION: |

|  |
| --- |
| DETAILS OF OTHER SERVICES INVOLVED: |
| NAME | ADDRESS | CONTACT NO | INTERVENTION |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| SUMMARY OF CONCERNS (Type of drug use, frequency of use, how this is impacting on young persons wellbeing, health, relationships, education/employment, criminal involvement, etc. Young persons views about their drug use) |
|  |

|  |
| --- |
| ANY KNOWN RISKS |
|  |

Social Work Services

Lomond View Academy

Ingleston Street

Greenock

PA15 4UQ

**Tel: 01475 715020**

**Email:** Youthdrugteam@inverclyde.gov.uk

**For Office Use**

Date Referral Received:

Date of Allocation:

Allocated to: