**CGL Jigsaw Young People and Family Service**

**Drug and Alcohol Services for Young People under 19 including Specialist Family Support for Children and Adults.**

**‘Putting the pieces together’**

**REFERRAL FORM - YOU CAN PHONE US WITH A REFERRAL OR COMPLETE THIS FORM AND EMAIL IT TO:** **jigsaw@cgl.org.uk**

**PLEASE ENSURE ALL SECTIONS OF THIS FORM ARE COMPLETED**

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| 1. **REFERRER’S DETAILS**
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Date of Referral :………………………………………………………

Is this referral for: Young Persons treatment? [ ]  *Is the Young Person at immediate risk if they do not receive a service?* YES [ ]  NO [ ]

 Parent/carer/family support including Children and/or Young People impacted by parental substance use? [ ]

Referrer’s Name: …………………………………………………………………. Position: ……………………………………………………………......................................

Agency Name & Dept.: ………………………………………………………………………………………………………………………………………………..………………………

Referrer’s Address:.........................................................................................................................................................................................

Contact Telephone Number: ………………………………………………. Email: ………………………………………………………………….....................................

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| **2. PERSONAL DETAILS** |

Forename: …………………………… Surname: ………………………….. Date of Birth: ……………………… Age……….. Male [ ]  Female [ ]

Residential Address: ……………………………………………………………………………………………………………………………………………………………….................. Postcode: ……………………………………………. Telephone Number: ………………………………………Email:………………………………………………………………

Who is the substance user? Young Person [ ]

 Family Member [ ]  Please Specify…………………………………………………………….....................................................

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| 1. **Family Composition**
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Please list the names of adults and children within the home and significant adults not living in the home:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  | **Gender:**  | **DOB/Age:** | **Ethnicity:** |
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| **3. YOUNG PERSON DETAILS** |

Is the Young Person a looked after child? YES [ ]  NO [ ]

Has the Young Person given consent to be contacted at the above address & telephone number? YES[ ]  NO[ ]

Has the Young Person given consent to contact his/her Parent/Carer? YES[ ]  NO[ ]

Does the Young Persons Parent/Carer require support? YES[ ]  NO[ ]

Has the Young Person given consent to contact his/her GP: YES[ ]  NO[ ]

Disability/Special Needs: …………………………………………………………………….. Language Needs: ……………………………………………………………………..

School/ College Name and Address:.............................................................................................................................................................

Name and contact of School Lead (If Known): ……………………………………………………………………………………………………………………………………….

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| **3. 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): |  |
| **4. SUBSTANCE USE** |

**PLEASE INDICATE MAIN DRUG OF CHOICE WITH AN X**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol  | [ ]  | Amphetamine | [ ]  | Benzodiazepines | [ ]  |
| Cannabis | [ ]  | GHB | [ ]  | LSD / Poppers | [ ]  |
| Cocaine | [ ]  | Magic Mushrooms | [ ]  | Solvents | [ ]  |
| Heroin | [ ]  | Methadone  | [ ]  | Novel Psychoactive Substances | [ ]  |
| Ecstasy | [ ]  | Ketamine | [ ]  | Tobacco | [ ]  |
| Crack Cocaine | [ ]  | Steroids | [ ]  | Unknown | [ ]  |

Other (please specify): ………………………………………………………..… If abstinent please state approximate time:…………………………………………...

 Is substance user injecting? YES [ ]  NO [ ]

***Substance misuse History:***

Please include the frequency of use, whether the individual is injecting, currently prescribed any medication and the client’s main view of the problem.

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***Reason for Referral:***

For example; the client wishes to receive substitute prescribing, detoxification, counselling or their physical/mental health has deteriorated and/or Family/parent carer requires support.

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| **7. Holistic Support** |

If yes, please list the names of the agencies and contact below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Agency** | **Name of Keyworker/Lead Person** | **Contact Tel. No. & Email** | **Consent Y/N** |
| YOT  |  |  |  |
| Community Mental Health |  |  |  |
| Social Service (Adult,Children,Families) |  |  |  |
| GP |  |  |  |
| Other: |  |  |  |
| Other: |  |  |  |

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| **8. METHOD OF CONTACT AND CONSENT** |

Does the person give consent to this referral and to enter their information onto our Database? YES [ ]  NO [ ]

Where does the person wish to be seen?………………………………………………………………………………………..

Preferred method of contact:

Letter [ ]  Text [ ]  Telephone Call[ ]  Telephone Call [ ]  Via referrer [ ]

 (Mobile) (Home)

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| **9. Risk/Additional Information** |

***Are there any significant risks which the service should be aware of?*** Yes No

If yes please provide further information below around the details and nature of risk:

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**This is to ensure that Staff are kept safe and it will provide additional information which will assist the service manage the needs and any risks associated with this client, so please be concise.**

**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 Jigsaw Young People and Family Service**

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

**Email: jigsaw@cgl.org.uk**

 **or referrals can be taken over the phone on 0115 948 4314**