

How to refer:-

To discuss the referral please contact us on:-

01723 330730 (option 2) / 08000 14 14 80 (option 2)

Via email: [humankind.nyyp.admin@nhs.net](mailto:humankind.nyyp.admin@nhs.net)

or [nyyp.admin@humankindcharity.org.uk](mailto:nyyp.admin@humankindcharity.org.uk) (secure from NYCC email addresses.

NYYP.admin@humankindcharity.org.uk

NY RISE Young People’s Drug and Alcohol Service

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | D.O.B | |  |
| Address |  | Postcode | |  |
| Education status School/ College/ Employment/ NEET |  | Preferred Pronoun | |  |
| Gender | |  |
| Disability | Yes (please provide details) | No | | Prefer not to say |
| Youth Justice Service Involvement | Yes | No | | |
| Looked after child | Yes | No | | Prefer not to say. |
| Social care Involvement | Yes (Record contact details) | | | No |
| Does YP have any communication needs? | Eg hearing / sight / speech / translation?  Yes – please provide details. | | No | |
| Contact details for YP/ Parent |  | | | |
| Details of other agencies involved |  | | | |
| Referrer details (Name, Contact number, role/relation to YP) |  | | | |

|  |  |  |
| --- | --- | --- |
| Is the young person aware of referral? | Yes | No |
| Parent/carer aware of referral? | Yes | No |
| What support would the YP want from our service? |  | |
| Where does the YP want to be seen?  Are they comfortable with virtual intervention eg phone / video call? |  | |
| Preferred Contact Method? Phone/Letter/Text/social media |  | |

Current substance use

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Substance | Frequency (eg daily/weekly) | Method of use (eg sniff, smoke) | Amount | Further info (eg how long used for) |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

Any risks of H/V to worker when meeting YP

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In the box below please record any additional concerns for the young person e.g., Mental health, self-harm, CSE/CCE, attendance at A&E due to drug/alcohol use, homelessness, NEET, Drug debt, domestic violence, involved in offending pregnancy, family drug/alcohol use.

**Internal Use Only:**

|  |  |
| --- | --- |
| **Date of Referral:** |  |
| **Name of Worker taking referral:** |  |