**CYPDAS – Warwickshire Children and Young People’s Drug and Alcohol Service - Referral Form**

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| ***Please email or post referrals to Compass:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Compass – Valiant Office Suites, Lumonics House, Valley Drive, Rugby, CV21 1TQ Telephone: 01788 578227  Secure Email: [compass.warksypsduty@nhs.net](mailto:compass.warksypsduty@nhs.net) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PRIVACY NOTICE STATEMENT Please note by completing this referral, Compass will require the following:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Yes √** | |
| **Young Person** | | | By consenting to this referral form being completed you will be consenting for Compass to hold your information on our database and for Compass to contact you to discuss your referral. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **The Referrer** | | | This referral has been discussed and agreed with the young person | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Are you making this referral without the young person’s consent under Working Together legislation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Please indicate  Yes  No | |
| If Yes to the above question, please provide a brief outline for safeguarding referral? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Have you obtained the consent from the parent/carer to make this referral? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | |
| You have explained that any information held on this form will be stored by Compass on a secure database. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **Signed by Referrer**  *(****electronic signature is acceptable)*** | | |  | | | | | | | | | | | | | **Signed by Young Person/parent or carer** *(Please make every effort to seek the young persons signature)* | | | | | | | |  | | | | | | | | | | | | | | |
| **Contact Details of Young Person:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Young Person:** | | | |  | | | | | | | | | | | | | | | | | | **Date referral made:** | | | | | | |  | | | | | | | | | |
| **Address** |  |  | | | | | | | | | | | | | | | | | | | | **Postcode** | | | | | | |  | | | | | | | | | |
| **YP Mobile number:** | | | |  | | | | | | | | **Home tel. no.** | | | | |  | | | | | **Is Accommodation Stable?** | | | | | | | **Yes** | | | | | | | **No** | | |
| **Date of Birth:** | | | |  | | | | | **Ethnicity** | | | | |  | | | | | | | | | | | | | | | **Age** | | | |  | | | | | |
| **Any SEN/Disability:** | | | | Yes  No  If Yes please give brief description: | | | | | | | | | | | | | | | | | | | | | | | | | | **Religion** | | | | |  | | | |
| **Is young person in Local Authority Care?** | | | | | | | | Yes  No | | | | | **Young Person’s Email:** | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Is young person known to social care?** | | | | | | | | Yes No | | | | | **Early Help** | | | | |  | | | | **CIN** |  | | | | | | **CP** | | | |  | | | | | |
| **How would the young person like to be contacted by Compass?** | | | | | | Post to home address | | | | | | |  | | Call to home telephone | | | | | | |  | Call to YP mobile | | | | | | | | |  |  | | | | | |
| School/agency appointment | | | | | | |  | | Other: please specify | | | | | | | |  | | | | | | | | | | | | | | | |
| **Is the young person happy for a telephone message**  **to be left for them?** | | | | | | | | | | | | | Their Mobile | | | | | | | | | Yes  No | | | | | | Parent/Guardian: | | | | | Yes  No | | | | | |
| Home telephone | | | | | | | | | Yes  No | | | | | |  | | | | | | | | | | |
| **Is the Young Person’s parent/guardian aware of the referral?** | | | | | | | Yes | | |  | | | **How does the Young Person describe themselves?** | | | | | | | Female | | | | | | Male | | | | | | | | Non-binary | | | | |
| No | | |  | | | Transgender | | | | | | Intersex | | | | | | | | Other/Prefer Not to Say | | | | |
| **Contact Details of Referrer** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | Relationship to young person: | | | | | | | | | | | | | | | | | | | | | | | | |
| Organisation: | | | | | | | | | | | | | | Mobile no: | | | | | | | | | | | Landline: | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | Email: | | | | | | | | | | | | | | | | | |
| **Reason for the Referral of the young person: tick reason that best suits this referral (please complete in detail below)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Substance Misuse** | | | |  | **Hidden Harm** | | | | | |  | |  | | | | | |  | | |  | | | | |  | | | |  | | | | | | |  |

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| **Reason for Referral:** |

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| **Are any other agencies currently involved in supporting the young person** | | | |
| Agency |  | Professional contact name/details |  |
| Agency |  | Professional contacts name/details |  |

**Section 2**

**Written Consent from Parent/Carer is required below if the child is aged 12 or under.**

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| **Storing your Information** |
| NDTMS is the National Drug and alcohol Treatment Monitoring System (NDTMS). It is used by Public Health England to collect information about drug and alcohol treatment in England. If you consent, your treatment service will share some of your child’s treatment information with NDTMS.  Pubic Health England collects some personal information about people in treatment including your child’s initials, date of birth, gender, a clinic or national prison ID number unique to your child, the local authority area in which you live and the first part of your postcode. This reduces the risk of you being counted twice. This information is only shared with Public Health England if you agree. Public Health England never contacts service users.  • your child’s full name and address are NOT passed on to Public Health England  • no identifiable information held on NDTMS is passed on to the police or criminal justice agencies  • your child’s information is held on NDTMS for at least 8 years and in some cases longer where required for a purpose    The information is used to understand how many people are using these treatment services, how good they are at helping people with substance misuse issues, to help improve them and produce statistics and research about drug and alcohol use and treatment.  If you do not want information about your child to be passed on to NDTMS then you have the right to say this or ask for your treatment information at your current treatment provider to be removed. This will not have any impact on the treatment you receive. You can ask your service or your keyworker for a copy of the NDTMS patient information leaflet for more information. |

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| **Consent** |
| This form records your consent to collect relevant information about your child and to store this information securely within Compass and with other third parties. Your Compass practitioner will explain this to you so you can make informed decisions about what is shared and with whom. |

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| **Confidentiality** |
| No information about your child is ever shared with any other agency without your permission unless it is necessary to keep your child or others safe from harm. If this was the case, we will explain to you why we need to share such information and where possible involve you in how the information is shared.  Your child’s personal information whether electronic or paper will always be stored securely. |

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| **Information sharing with other agencies** |
| We will only share information about your child with other agencies/professionals involved in your child’s care with your consent unless we believe your child or others are at risk of harm, or we have a legal obligation to release the information to statutory organisations (e.g. CQC/Ofsted).  We will discuss with you which agencies/professionals you consent to us sharing information with. Compass will actively encourage you to share information where it supports the care/treatment your child is receiving from us and from other professionals. This will ensure that there is good co-ordination and communication between professionals and reduces any unnecessary duplication. |

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| **Consent to Hold and Share Information** |
| 1. As part of your child’s care Compass may need to share information, as appropriate, with other   agencies such as Childrens Social Care and Education. Please tick to agree Compass sharing information   1. As described above, Compass will hold personal details regarding you and your child within its   Secure Database. Please tick to agree for Compass to hold your personal information. |

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| **Parent/Legal Guardian\*** |  |  |
| Name: | Signature: | Date: |