REFERRAL TO YOUTH DRUG AND ALCOHOL CLINICAL SUPPORT NETWORK – (YDACSN)

Please tick which program your referral is for:

☐ Drug & Alcohol Counselling for a child/young person (**complete referrer details & Part A only**)

☐ Clinical Consultation in regards to child/young person or group of children/young people (**complete referrer details & Part A only**)

☐ Request for service capacity building – Education/Training (**complete referrer details & Part B only**)

Once referral is completed, please email through to WNSWLHD-YDACSN@health.nsw.gov.au

Referrer Details		
Referrer's Name:	Relationship to client:	Date of Referral:
Address:		Contact No#:
Email address:		

PART A

Client Information		
Client's Last Name:	Client's First Name:	Date of Birth:
Address:		
Phone:	*Is this the client's number or their parent/guardian?* _____ *Permission to leave message? ☐ Yes ☐ No*	
Is the client at risk of homelessness? ☐ Yes ☐ No ☐ Unknown		
Email address:		MRN:
Gender: ☐ Female ☐ Male ☐ Prefer not to say ☐ Other _____		

Has the client consented to this referral being made? ☐ Yes ☐ No		
Is the client in an Out of Home Care (OOHC) placement? ☐ Yes ☐ No *If yes, which agency is the client Case Managed by:*		
Cultural & Religious Information		
Cultural Identity: ☐ Aboriginal ☐ Torres Strait Islander ☐ CALD ☐ Other		
Country of Birth:	Language/s spoken at home other than English:	Requires an Interpreter? ☐ Yes ☐ No
Does the client identify with a particular religion and/or spiritual denomination?	☐ Yes ☐ No ☐ Unknown *If yes, please provide details.*	
Substance Use Information		
Presenting Substance Use Concerns	Primary Drug of Concern? *Please provide details:*	
	Secondary Drug of Concern? *Please provide details:*	
Family & Support Network Information		
<u>Current Guardian Details</u>		
Guardian 1 Name:	Address:	Phone: *Permission to leave message? ☐ Yes ☐ No*
Email address:	Cultural Identity:	Requires an Interpreter? ☐ Yes ☐ No
Relationship to client: Does the client live with this person? ☐ Yes ☐ No Does this person have legal guardianship of the client? ☐ Yes ☐ No		
Guardian 2 Name:	Address:	Phone: *Permission to leave message? ☐ Yes ☐ No*
Email address:	Cultural Identity:	Requires an Interpreter? ☐ Yes ☐ No
Relationship to client: Does the client live with this person? ☐ Yes ☐ No		

Does this person have legal guardianship of the client? ☐ Yes ☐ No	
Brief Family Background	*(Family details including, status of clients relationship with family members/significant others, families knowledge of clients substance use, level of support the family provides to client)*

Emergency Contact Details

Tick this box if details are the same as current guardian ☐

Contact's Name:	Address:	Phone:
Email address:	Relationship to child/young person:	Requires an Interpreter? ☐ Yes ☐ No

Support Service Details

Please tick all applicable boxes & provide details: Department of Communities & Justice: - ☐ Children, Family & Carers (Child Protection) ☐ Youth Justice	Government Health Services: - ☐ Community Health ☐ Drug & Alcohol Services ☐ Mental Health Services - CAMHS
☐ Headspace ☐ PCYC ☐ Mission Australia ☐ Doctor ☐ Education provider	☐ Aboriginal Health Service ☐ NDIS Provider ☐ Other _____ ☐ Other _____

Contact details of any support services engaged with client:

Service:	Worker's Name:	Phone:	Email:
Service:	Worker's Name:	Phone:	Email:
Service:	Worker's Name:	Phone:	Email:
Service:	Worker's Name:	Phone:	Email:

Education, Training & Vocation Information

Is the client engaged in any education, training or vocation? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):

Is the client interested in pursuing any education, training or vocation? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):

Health & Medical Information

Any Significant Health/Medical Conditions, please provide details:	
Does the client have any known Disabilities? ☐ Yes ☐ No	Please provide details of any disabilities (including any NDIS providers also engaged with the client):
Current Prescribed Medications:	
Any known allergies? ☐ Yes ☐ No	Please provide details, reactions, treatment:
Medicare Number:	Has the client had a Hospital admission for Mental health issues within the past 2 years? ☐ Yes ☐ No ☐ Unknown *If yes, please provide a copy of the Hospital Discharge Summary.*
Does the client have a current Community treatment Order? ☐ Yes ☐ No ☐ Unknown *If yes, please provide details.*	
Does the client have a history of trauma? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):
Has the client attempted to end their life? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):
Has the client engaged in self-harm? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):

Legal

Does the client have a criminal history? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):
Any acts of aggression/violence in the criminal history?	Please provide details (including dates):

☐ Yes ☐ No ☐ Unknown	
Any police charges, outstanding matters, court dates? ☐ Yes ☐ No ☐ Unknown	Please provide details (including dates):

The above information is true to the best of my knowledge.		
Referrers Name:	Signature:	Date:

PART B

Request for Service Capacity Building – Education/Training

(only complete this section if you are requesting capacity building/training for your service)

Does your service work with youth aged 10 – 18 years who are engaging in experimental, recreational, situational or compulsive substance use?

☐ Yes ☐ No *If yes, pleases select from the support options below*

Support options:

☐ Education, training, tools and resources to enhance the capacity of your service to deliver a range of evidence based drug and alcohol interventions;

☐ Assistance with screening, assessment, care planning, treatment & care coordination for youth with complex needs;

☐ Links to local services and referral pathways to support coordination of care between service providers.

Please provide details of your support request:

The above information is true to the best of my knowledge.		
Referrers Name:	Signature:	Date: