**CheckPoint Young Peoples Drug and Alcohol Service for Under 18’s**

**T: 01803 200100 E:** **checkpoint.torbay@nhs.net**

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| **Name:** | **Address:**  |
| **Date of referral:** |
| **Date of birth:** |
| **Age:** | **Gender assigned at birth:****Gender** (identifies as) |
| **Ethnicity:****White: British/ Irish/ Other** **Gypsy, Romany, Irish Traveller****Mixed/multiple**: White and Black Caribbean/ White and Black African/ White and Asian/ Other**Asian or Asian British**: Indian/ Pakistani/ Bangladeshi/ Chinese/ Other**Black or Black British**: Caribbean/ African/ Other**Arab Other ethnic group Refused Not known** |
|  **DISABILITY Please circle****A.** No disability**B.** Social/communication impairment such asAsperger’s syndrome/other autistic spectrum disorder**C.** Blind or have a serious visual impairment **D.** Deaf or have a serious hearing impairment**E** You have a long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy | **F.** Specific learning difficulty such as dyslexia,dyspraxia or AD(H)D**G.** Physical impairment or mobility issues, such asdifficulty using your arms or using a wheelchair or crutches**H.** Disability, impairment or medical conditionthat is not listed above**I.** Two or more impairments/and or disabling medicalconditions |
| Please give details of any additional requirements or provision to enable them to access the service? i.e. interpreter service, wheel chair access etc. |
| **Religion:** 🔿 unknown/not stated 🔿 practising (please say which)  |
| **Referrer name: Organisation** (if applicable):**Contact details:** **Referrer relationship to young person**: |
| **Name of person completing this referral:** |
| **Times, days available for an appointment?** (if known) |
| **How can we contact you/them?** (Please give at least one phone number)🔿 phone – mobile 🔿 phone – landline 🔿 text 🔿 other method (please specify)………………………**Phone numbers:**Young Person.………………………….…………………………………………………………………………………Parent/Carer.………………………….…………………..Name……………………………………………………**Email address:** (if known)Young Person.………………………….…………………………………………………………………………………Parent/Carer.………………………….…………………..Name…………………………………………………… |
| **Is young person aware of this referral?  yes  no****Has the Young Person given consent to treatment at CheckPoint  yes  no****If no……………. Young Person will not be contacted until consent is provided.**  |
| **Is parent/carer aware of this referral?  yes  no** |
| **Is this young person in local authority care?  yes  no****If yes please give details** |
| **Is the Young person subject to a YJS order?  yes  no****If yes please give details including allocated JYS worker** |
| **Please give details of any risk we should be aware of?****Could this Young person pose any risk to the practitioner?  yes  no****If yes please explain** |
| **Does the Young person have any neurodiversity’s that we need to be aware of?  yes  no****If yes please explain….** |
| **Are there any other agencies involved?****If yes please provide details i.e. name, agency, contact number**  |
| **Please provide details on young Persons education, training and employment.*** + Full-time education at school college (name) / EHCP
	+ Training programme / Employment name
	+ Other (please describe)
 |

**Current Substance Use**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug name | Amount | Frequency | Route | Age at first use |
| Alcohol |  |  |  |  |
| Cannabis |  |  |  |  |
| Ecstasy |  |  |  |  |
| Cocaine |  |  |  |  |
| Amphetamine |  |  |  |  |
| Ketamine |  |  |  |  |
| Acid |  |  |  |  |
| Mushrooms |  |  |  |  |
| Other |  |  |  |  |

Frequency: Daily, Weekly, Monthly, Occasional, Binges

Route: Oral, sniffed/ snorted, smoked, injecting, unknown, other route.

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| **Has the Young Person received Drug and Alcohol treatment previously?****What have they/you used in the past week?**Is this typical?**Does anyone else see their/your substance use a problematic?** |