Youth Drug & Alcohol Clinical Service (YDACS) Referral Form

YDACS is a voluntary service for young people between ages of 12 – 18, who have "moderate to severe" substance use problems. This means that the substance use may be impacting on a young person's school attendance, relationships, physical and mental health and overall wellbeing.

YDACS can only engage with young people who have consented to the referral so please ensure you have discussed YDACS and the referral with the young person. Information about YDACS available on our website http://www.hnekidshealth.nsw.gov.au/site/ydacs

PLEASE EMAIL COMPLETED FORM TO HNELHD-YouthDACS@health.nsw.gov.au

For any enquiries, please contact YDACS on 1800 950 755

ELIGIBILITY CRITERIA			
Young person is aware of & consented to the referral	☐ yes	☐ no	☐ unsure
Young person is 18 years or younger	☐ yes	☐ no	☐ unsure
Young person has moderate to severe substance use	☐ yes	☐ no	☐ unsure

YOUNG PERSON DETAILS						
Surname	Click here to enter text.			Given names	Click here to enter text.	
Aliases	Click here to enter text.					
Gender	Male ☐ Female ☐ Other: Click here to enter text.					
D.O.B.	Click here to enter a date.	Age:	Click here to enter text.		MRN	Click here to enter text.
Pregnant	☐ yes	☐ no	N/A ☐	Children	☐ yes	☐ no
Cultural Identity	Aboriginal ☐ Torres Strait Islander ☐ Other:					
Residential Address	Click here to enter text.					
Mobile Number	Click here to enter text.			Email address:	Click here to enter text.	
Are DCJ involved	☐ yes ☐ no	Details: Click here to enter text.				
Is the young person a current inpatient				☐ yes	☐ no	
Hospital & ward	Click here to enter text.					
Reason for admission	Click here to enter text.					
Planned/expected discharge date if known		Click here to enter text.				
Planned discharge destination		Click here to enter text.				

PARENT/CARER DETAILS				
Surname	Click here to enter text.	Given names	Click here to enter text.	
Relationship to young person	Choose an item.	Click here to enter text.		
Residential address if different to young person		Click here to enter text.		
Mobile number	Click here to enter text.	Home number	Click here to enter text.	
Is the listed parent/carer aware of the referral		☐ yes	☐ no	☐ unsure
Level of family/carer support		☐ high	☐ moderate	☐ low

REASON FOR REFERRAL (including expected outcomes)
Click here to enter text.

PRIMARY SUBSTANCE USE (tick one) – include when last used						
☐ alcohol	☐ cannabis	☐ cocaine	☐ amphetamines	☐ benzodiazepines	☐ opioids	☐ heroin
☐ other	Details: Click here to enter text.					
OTHER SUBSTANCES USED (tick all that apply) – include when last used						
☐ alcohol	☐ cannabis	☐ cocaine	☐ amphetamines	☐ benzodiazepines	☐ opioids	☐ heroin
☐ other	Details: Click here to enter text.					
CURRENT SUBSTANCE USE (include amount and route of administration e.g. ingested, smoked, injected)						
Click here to enter text.						
PAST SUBSTANCE USE AND ANY PREVIOUS TREATMENT						
Click here to enter text.						

CURRENT LIVING ARRANGEMENTS/FAMILY FUNCTIONING		
Click here to enter text.		
PSYCHOSOCIAL ISSUES/RISKS		
History of past trauma	☐ yes ☐ no ☐ unsure	☐ physical ☐ sexual ☐ neglect ☐ emotional abuse ☐ witness to domestic violence ☐ other
	Details: Click here to enter text.	
Present trauma	☐ yes ☐ no ☐ unsure	☐ physical ☐ sexual ☐ neglect ☐ emotional abuse ☐ witness to domestic violence ☐ other
	Details: Click here to enter text.	
History of self-harm	☐ yes ☐ no ☐ unsure	Details: Click here to enter text.
Suicidal ideation	☐ yes ☐ no ☐ unsure	Details: Click here to enter text.
Suicide attempt	☐ yes ☐ no ☐ unsure	Click here to enter a date. Details: Click here to enter text.

Other psychosocial risks including school attendance, risk of homelessness etc.
Click here to enter text.

MEDICAL, BEHAVIOURAL, DEVELOPMENTAL, MENTAL HEALTH CONCERNS +/- DIAGNOSIS (including current treatment)
Click here to enter text.

CURRENT PRESCRIBED MEDICATIONS
Click here to enter text.

STRENGTHS AND PROTECTIVE FACTORS
Click here to enter text.

NAMES AND CONTACT DETAILS OF OTHER SERVICES INVOLVED		
CAMHS	☐ yes ☐ no	Click here to enter text.
Headspace	☐ yes ☐ no	Click here to enter text.
DCJ	☐ yes ☐ no	Click here to enter text.
Juvenile Justice	☐ yes ☐ no	Click here to enter text.
Nexus	☐ yes ☐ no	Click here to enter text.
School staff	☐ yes ☐ no	Click here to enter text.
GP	☐ yes ☐ no	Click here to enter text.
Community health service	☐ yes ☐ no	Click here to enter text.
Other	Click here to enter text.	

REFERRER DETAILS	
Date	Click here to enter a date.
Referring service	Click here to enter text.
Referrers name	Click here to enter text.
Referrers title	Click here to enter text.
Referrers email	Click here to enter text.
Referrers contact number	Click here to enter text.