**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](mailto: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. |