REFERRAL FORM – ALCOHOL INTERVENTION MEDIATION SERVICE

Coventry Cyrenians
Oakwood House, Cheylesmore, Coventry, CV1 2HL
Switchboard: 024 76228099 **DDI:** 024 76527891 **Fax:** 024 76221899
Email phil.smith@coventrycyrenians.org or izzy.hawkins@coventrycyrenians.org

This form is to be used if you or a client you are working with wish to be considered for our Alcohol Intervention Mediation Service. Please complete this form and send it to the address as detailed above. Alternatively an enquiry can be made by calling the telephone number above. We can provide you with a service leaflet but you can also visit our website at www.coventrycyrenians.co.uk for further details.

Referrer Details	
Name of Agency	
Name of Referrer	
Referrer Contact Number (land-line including extension)	
Referrer Mobile Number	
Referrer Fax Number	
Referrer E-mail Address	
Date of Referral	

Young Person's Details	
Full Name	D.O.B & Age
Financial Status (including whether the client is entitled to public funds)	Gender
Ethnic Origin	Religion
Tel No / Mobile	Ni No
Client No. (Cyrenians use only)	
Education Need Yes ☐ No ☐	YP Aware of Referral Yes ☐ No ☐
Current Address & circumstances *(e.g. living with family/parents/carers etc)*	

Parents / Carers Details	
Full Name	**D.O.B**
Tel No	**Mobile**
Current Address (if different from above)	
Parents / carers aware of the referral **Yes** ☐ **No** ☐	
Please state how the young person or parent / carer wants to be contacted	

Education Status	
Name of School / College / Education Provider **Name of Lead Contact** **Telephone Number of Lead Contact** **Email Address of Lead Contact**	

Support Needs *(does the client have any of the following support needs – tick those that apply)*				
	Alcohol			Sexual exploitation (or at risk of)
	Drugs			Offending behaviour
	Absconding from home			Conflict with family
	Sex work			Anti-social behaviour
	Housing			Access to education / training
	Mental Health			Access to work
	Self-harm			Bullying
	Physical Health			Community Involvement
	Learning Disability (Statemented)			Claiming benefits
	Debts / Budgeting			Domestic violence
	Gambling			Other (Please state)

Reason for Referral *(include current circumstances, any risks to young person, substance misuse, sexual exploitation, absconding from home, please continue on separate sheet if required)*

Are there any mental or physical health issues that should be taken into account?
(include self-harm & suicide risk; please give details of any medication)

Are you aware of any risk factors that should be taken into account as part of the referral, e.g. convictions, risk to others etc*?* *(continue on a separate sheet if necessary)*

Are any other agencies involved with the client? *(please state the name of the agency, the name of the worker and their contact details – address, telephone number and email)*

Any other information to assist in assessing the client, such as them being a young carer, their availability etc

Signed (Referrer)	**Date**