

**In line with GDPR guidelines the Milton Keynes Youth Drug and Alcohol Solutions (YDAS) team will not be able to process this referral without the requirements outlined in the privacy notice below being met.**

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| **Privacy Notice Statement** |
| **Please note by completing this referral, the YDAS team will expect the following:*** **This referral has been discussed and agreed by the referred young person.**
* **You consider the young person to have capacity to give informed consent.**
* **You have explained that any information held on this form will be stored by Milton Keynes City Council on a secure database.**

Signed by referrer ………………………………………………………………………………….Signed by Young Person referred …………………………………………………………… |

**Section 1**

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| **Date Received by YDAS**  | **Date Allocated to YDAS** | **Date 1st Appointment Offered** |
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| **Please tick the box below if this referral is for:**  | **Please tick the box below if this referral is for:** |
| **A young person affected by their own drug and alcohol use.***Complete Section 1 & Section 2 if the young person is aged 12 or younger*  |  | **A young person affected by someone else’s drug and/or alcohol use (i.e., parent/carers)***Complete Section 1 & Section 2 if the young person is aged 12 or younger*  |  |
| **Details of Referrer** |
| **Name** |  |
| **Organisation** |  | **Relationship** |  |
| **Address** |  |
|  | **Postcode** |  |
| **Landline**  |  | **Mobile**  |  |
| **Email Address** |  |
| **Details of Young Person** |
| **Is the Young Person aware of the referral?**  |  |
| **Is the Young Person’s Parent/Carer aware of the referral?** |  |
| **Young Person’s Signature to Consent to Referral**  |  |
| **Name** |  |
| **Address** |  |
|  | **Postcode** |  |
| **Landline** |  | **Mobile** |  |
| **Name of parent/carer & Mobile number** |  |
| **Date of Birth** |  | **Age** |  | **Gender** |  |  |
| **Nationality** |  | **Ethnic Origin** |   |
| **Registered Disabled** | 🞏 Yes | 🞏 No | **Primary Impairment** |  |
| **Registered with GP** | 🞏 Yes | 🞏 No | **Surgery Name** |  |
| **Is the young person current subject to the following:** | 🞏 EHA | 🞏 CIN 🞏 CPP 🞏LAC |  |  |
| **Do you consent to the following methods of contact?**  | 🞏 Email |  🞏Landline 🞏 Mobile |  | 🞏 Referrer |
| **Known substance issues** |  |
| **Identified risks** |  |
| **Where would the young person feel most comfortable meeting?** |  |
| **Would the young person like to be accompanied?** **Would the referrer like to attend the initial meeting?** **Will family/carer be involved in support?** |  |
| **Is there anything we need to know that could support engagement?** |  |
| **Other Agencies Involved in Supporting the Young Person** |
| Agency & Practitioner  |  | Contact Number |  |
| Agency & Practitioner |  | Contact Number |  |
| Agency & Practitioner |  | Contact Number |  |
| Agency & Practitioner |  | Contact Number |  |
| **Please email completed referral forms to the Milton Keynes YDAS team at:** **ydas@milton-keynes.gov.uk** |

**Section 2**

***Written Consent from Parent/Carer is required below if the young person is aged 12 or under.***

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| **Consent** |
| This form records your consent to collect relevant information about your child and to store this information securely within Milton Keynes Council and to share (when appropriate) with other third parties. Your Youth Drug and Alcohol Solutions worker will explain this to you so you can make informed decisions about what is shared and with whom. |
| **Confidentiality** |
| No information about your child is ever shared with any other agency without your permission unless it is necessary to keep your child or others safe from harm. If this was the case, we will explain to you why we need to share such information and where possible involve you in how the information is shared. Your child’s personal information whether electronic or paper will always be stored securely. |
| **Information sharing with other agencies** |
| We will only share information about your child with other agencies/professionals involved in your child’s care with your consent unless we believe your child or others are at risk of harm, or we have a legal obligation to release the information to statutory organisations. We will discuss with you which agencies/professionals you consent to us sharing information with. The Youth Drug and Alcohol Solutions team will actively encourage you to share information where it supports the care/treatment your child is receiving from us and from other professionals. This will ensure that there is good co-ordination and communication between professionals and reduces any unnecessary duplication. |
| **Consent to Hold and Share Information** |
| 1. As part of your child’s care, the Youth Drug and Alcohol Solutions team may need to share information, as appropriate, with other agencies such as Children’s Social Care and Education. Please tick and/sign to agree to sharing information.
2. As described above, the Youth Drug and Alcohol Solutions team will hold personal details regarding you and your child within their secure database. Please tick to agree for Youth Drug and Alcohol Solutions team to hold your personal information.
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| **Parent/Legal Guardian\*** |
| **Name:** | **Signature:** | **Date:** |