**REFERRAL FORM**

(Substance Abuse Service Specific to Youth – North Dublin city and county)

S.A.S.S.Y. Lisburn St, Dublin 7, D07E891 sassy@hse.ie 24hr Message Service: 01 7785980

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| --- | --- | --- |
| **Name:**  |  |  **Date of Birth:** **F**  |
| **Address / Eircode:** |  | **Name and phone number for parent / guardian:** |
| **Current Accommodation** **(if different to the above):**  |  | **Date of Referral:** |
| **Referrer name /service & address:**  |  | **Referrer Name/Phone/Email:** |
| **Reason for Referral:** |  |
| **Drug Use History:** |  |
| **Mental Health Concerns:** |  |
| **Diagnosis (if any) and service(s) attending:** |  |
| **Behavioural Issues:** |  |
| **Family Composition:** |  |
| **Other Professionals** **involved:** |   |
| **Client view of referral** |

|  |  |
| --- | --- |
| MOTIVATED  | RELUCTANT  |
| INDIFFERENT  | UNAWARE  |

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