**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](mailto: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 | | |