

# Gloucestershire Young People's Substance Misuse Referral Form

Contact us:	
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## Young Person

Name .....

Date of Birth...../...../.....

Male / Female

CAF: Yes / No

\*Contact:

Mobile:.....

e-mail:.....

\*This information will help the young person to directly access appropriate services, however limited information may delay support.

Address\*

.....  
 .....  
 .....  
 .....

\*- Only required for specialist referral

## Referrer Contact Details .

Name:.....Please indicate if you have completed screening training Y/N?

Organisation: .....

Telephone.....

e-mail.....

Lead Professional: Yes / No.....(Name if different from above)

I consent to this information being shared with services for the purpose of this referral

Young Person's Signature

Date

*In normal operating conditions referrals will be picked up between Mon – Fri 9am – 5pm. Outside of these hours referrals will be picked up on the next working day. In the event of an emergency, please act in accordance with normal emergency procedures.*