# **Referral to The Link Youth Health Service**

# **Alcohol, Tobacco, and Other Drugs Program**

**A:** 57 Liverpool Street Hobart 7000 l **P**: 03 6231 2927 I **F:** 03 6231 3908 l **E:** [hello@thelink.org.au](mailto:hello@thelink.org.au)

*It is important that the young person is aware of this referral and agrees to be referred to*

*The Link Youth Health Service Alcohol, Tobacco, and Other Drugs Program (ATOD).*

**Today’s date:**  **\_\_/\_\_/\_\_\_\_**

**Young person’s details:**

|  |  |  |
| --- | --- | --- |
| Name: | Preferred name: | Pronouns: |
| Mobile: | Home ph: | Date of Birth: |
| Address: | | |
| Email: | | |
| Do you have consent to share personal information? Yes ☐ No ☐ **If yes please attach consent form** | | |
| Which contact/s would the young person prefer us to use? Mobile ☐ Home ph ☐ Email ☐ | | |
| Can we use SMS to confirm appointments? Yes ☐ No ☐ | | |
| ***Is the young person?:*** | | |
| Aboriginal Yes ☐ No ☐ | Torres Strait Islander Yes ☐ No ☐ | |
| ***BOTH*** Aboriginal and Torres Strait Islander Yes ☐ No ☐ | ***NEITHER*** Aboriginal and Torres Strait Islander  Yes ☐ No ☐ | |
| Is the young person from a CALD background Yes ☐ No ☐ | If ***YES*** what is their cultural background? | |
| Do they need an Interpreter? Yes ☐ No ☐ | | |
| Does the young person need disability support? Yes ☐ No ☐ | If ***YES***, what support do they need? | |
| Comments: | | |

**Referrer Information**

|  |  |
| --- | --- |
| Your name: | Name of your organisation: |
| Phone: | Email: |
| Will you or another person from your service have ongoing involvement with the young person?  Yes ☐ No ☐ ***If YES please provide details:***  Name/s: Email/s: | |

**Appointment preference**

|  |  |  |
| --- | --- | --- |
| We can provide some flexibility around appointments; however, the young person must be in a private and confidential space. Please identify the young person’s appointment preference. | | |
| Face to face: Yes ☐ No ☐ | Phone: Yes ☐ No ☐ | Preferred suburb postcode: |
| Screen/Teams/Zoom etc:  Yes ☐ No ☐ | Other: | |

**ATOD issues**

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance used** | **Duration of current use** | **Frequency of use** | **Consumption/amount** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Stage of change/expectations:**  Brief summary: | | | |

**Mental health diagnosis/issues**

|  |  |  |
| --- | --- | --- |
| Depression: Yes ☐ No ☐ | Anxiety: Yes ☐ No ☐ | PTSD: Yes ☐ No ☐ |
| Psychotic disorder: Yes ☐ No ☐ | Eating Disorder: Yes ☐ No ☐ | Other: |
| Brief summary: | | |

**Additional information (if relevant)**

|  |  |
| --- | --- |
| Legal issues: Yes ☐ No ☐ | Family/relationship concerns: Yes ☐ No ☐ |
| Living skills/homelessness Yes ☐ No ☐ | Other: |
| Brief summary: | |

Please return this form to The Link Youth Health Service ATOD Program

**Email: hello@thelink.org.au** l P: 03 6231 2927 | F: 03 6231 3908 | GPO Box 844 Hobart TAS 7001

**Mandatory Reporting:** In Tasmania, mandatory reporting requirements are outlined in the [*Children, Young Persons and Their Families Act 1997.*](https://www.legislation.tas.gov.au/view/html/inforce/current/act-1997-028)

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