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

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

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

The ATOD program is unable to provide intensive support as we are not a tertiary service. Referrals will be accepted when it is safe and appropriate for the young person to engage with our program. If you have any questions regarding this referral, please call 6231 2927 to speak with one of our friendly ATOD workers

*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).*

|  |  |  |
| --- | --- | --- |
| Does this young person understand and consent to this referral? | Yes | *If not, the referral cannot be accepted. Please get in touch* with *us and we can talk through some other options.* |
| Is the young person between 12 and 25 years of age? | Yes |
| If under 16, are the young person's parents or carers aware of this referral? | Yes |
| Who is the best person to contact about this referral? | Young Person |   Guardian   |    Referrer | |
| Do you have any immediate concerns about the safety of the young person or others? | Yes | No | |

The Link Youth Health Service Alcohol Tobacco and other Drug Program is not an acute mental health service. If you have any immediate concerns for the safety of a young person, The Link is not an appropriate referral. Please call the Mental Health Helpline on 1800 332 388, direct the young person to the emergency department or call triple 000.

**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? | | |
| Does the young person have a GP? | Yes | No | Details of GP practice |  | |
| 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: | |

**EMERGENCY CONTACT DETAILS** (Parent or guardian required for young people under 16 years)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | Phone |  |
| Email |  | | | |
| Relationship to young person | |  | | |
| Street Address | |  | | |

**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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