Early Break hcrg Care Group

REFERRAL FORM

ALL OF THIS SECTION MUST BE COMPLETED IN FULL FOR US TO ACCEPT THE REFERRAL

First Name:	**Last Name:**	**Age:**	**Date of Birth:**	**Gender & Pronoun:**	**Nebula Number** (office use only): **Advocacy** **Advocacy & HCRG** **The Proud Trust**

Address: House number/Name/Street/Area/Town:

Postcode: **Consent to use this info to contact client? Y N**

Living with Parents/Relatives
Living independently/Settled Accom
YP Living in Care
Living independently/Unsettled Accom
Living independently/NFA
Living in Supported Housing
Child Looked After
YP Living in Secure Care

Home telephone:	Consent to use? **Y N**
Young person's mobile telephone:	Consent to use? **Y N**
Emergency Contact and relationship to YP **Name:** **Contact details**	Consent to use? **Y N**
Email Address:	Consent to use? **Y N**
School/College:	
Main Substance: **(*MUST be completed)**	
Other Substances:	
Does Parent/Guardian/Emergency Contact of YP know of this referral? YES NO	
Permission to contact them: YES NO Only in an emergency	

Young Person's Ethnicity:

Substance Related Concerns (reason for referral, please use separate sheet if needed):

Sexual Health Concerns (reason for referral, please use separate sheet if needed):

Young Person's Current Status:
Please click on the box for 'YES' or leave blank if not known (those ticked in BOLD require immediate referral to Virgin Care)

MH treatment need identified
In contact with YOT/YOS
Involved in Sexual Exploitation
Involved Self Harm
Involved in unsafe drug use
Involved in Offending
In contact with Disability Services
With Drug/Alcohol using parents/carers
Have a CAF/EHA
Currently Homeless
Young Carer
Currently Pregnant
Looked after by LA
Engaged in unsafe sex
Requires morning after pill
Requires contraception
Any STI symptoms
Any exposure to HIV

Young person's Education Status:

Any additional information about the young person:

Referral Source: Please ensure <u>ONE</u> of these is ticked

CLA – Child Looked After
Children & Family Services
Universal Education
Alternative Education
YOT/YOS
GP
Hospital/A&E
Relative/Peer/concerned other
Non-Child Mental Health Service
Adult Treatment Provider
Young People's Treatment Provider
Non-Treatment Subs Misuse Service
Self-referral
Youth Offending Institute
Children & YP secure estate
Employer
Post Custody
Targeted Youth Support
Outreach
YP Housing Provider
Primary Care
Children's MH Service
School Nurse
Self-referral via health professional
Crime Prevention

Please give details of any other services involved:

Referrer Contact Details: NAME/ADDRESS/E-MAIL

Do you require feedback from the intervention? YES NO

At risk of presenting difficult or violent behaviours:

Is the YP open to Social Care? YES NO

If yes, please expand:

Signature of Referrer:	**Date Referral sent to Early Break:**	**Name/information of Social Worker/Lead Professional:**

Return to: Early Break Head Office, Annara House, 7-9 Bury Road, Radcliffe, M26 2UG ***(charity no: 1072052)*** - T: 0161 723 3880 // F: 0161 723 5544 // e-mail: info@earlybreak.co.uk