



# REFERRAL FORM

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

First Name:		Last Name:		Pronoun:		Age:		Date of Birth: / /		Gender		Is the YP trans? Yes/No/Prefer not to say/Not Known		Database Number (office use only):					
Please use notes section if necessary																			
Address: House number/Name/Street/Area/Town						Living with Parents/Relatives <input type="checkbox"/>		Living independently/Unsettled Accom <input type="checkbox"/>		Child Looked After <input type="checkbox"/>									
						Living independently/Settled Accom <input type="checkbox"/>		Living independently/NFA <input type="checkbox"/>		YP Living in Secure Care <input type="checkbox"/>									
Postcode:						Consent to use this info to contact client? Y <input type="checkbox"/> N <input type="checkbox"/>		YP Living in Care <input type="checkbox"/>		Living in Supported Housing <input type="checkbox"/>									
Home telephone:				Consent to use? Y <input type="checkbox"/> N <input type="checkbox"/>		Young Person's Ethnicity:													
Young person's mobile telephone:				Consent to use? Y <input type="checkbox"/> N <input type="checkbox"/>		Notes (Please use additional sheet if needed):						Young Person's Current Status:: Please tick YES ✓ of NO X or 'NOT KNOWN' - leave blank							
Other Mobile Telephone				Consent to use? Y <input type="checkbox"/> N <input type="checkbox"/>								MH treatment need identified <input type="checkbox"/>		Have a CAF/EHA <input type="checkbox"/>					
Email Address:				Consent to use? Y <input type="checkbox"/> N <input type="checkbox"/>								In contact with YOT/YOS <input type="checkbox"/>		Currently Homeless <input type="checkbox"/>					
Main Substance: [*MUST be completed]												Involved in Sexual Exploitation <input type="checkbox"/>		Young Carer <input type="checkbox"/>					
Substance 2:						Involved Self Harm <input type="checkbox"/>		Currently Pregnant <input type="checkbox"/>											
Substance 3:						Involved in unsafe drug use <input type="checkbox"/>		Looked after by LA <input type="checkbox"/>											
Does Parent/Guardian of YP know of this referral? YES <input type="checkbox"/> NO <input type="checkbox"/>						Involved in Offending <input type="checkbox"/>		Engaged in unsafe <input type="checkbox"/>											
						In contact with Disability Services <input type="checkbox"/>		sex <input type="checkbox"/>											
						With Drug/Alcohol using parents/carers <input type="checkbox"/>													
Referral Source: Please ensure <u>ONE</u> of these is ticked														Young person's Education Status: Please tick YES ✓ of NO X or 'NOT KNOWN' - leave blank					
CLA - Child Looked After <input type="checkbox"/>		GP <input type="checkbox"/>		Adult Treatment Provider <input type="checkbox"/>		Youth Offending Institute <input type="checkbox"/>		Website <input type="checkbox"/>											
Children & Family Services <input type="checkbox"/>		A & E <input type="checkbox"/>		Young People's Treatment Provider <input type="checkbox"/>		Secure Training Centre <input type="checkbox"/>		Employer <input type="checkbox"/>		Mainstream Education <input type="checkbox"/>		Regular Employment <input type="checkbox"/>							
Universal Education <input type="checkbox"/>		Hospital <input type="checkbox"/>		Non Treatment Subs Misuse Service <input type="checkbox"/>		Secure Children's Home <input type="checkbox"/>				Alternative Education <input type="checkbox"/>		Unemployed and not seeking work <input type="checkbox"/>							
Alternative Education <input type="checkbox"/>		Non Child Mental Health Service <input type="checkbox"/>		FRANK Helpline <input type="checkbox"/>		Post Custody <input type="checkbox"/>				Temporarily Excluded <input type="checkbox"/>									
Targeted Youth Support <input type="checkbox"/>		Primary Care <input type="checkbox"/>		Self-referral via health professional <input type="checkbox"/>		Self <input type="checkbox"/>				Permanently Excluded <input type="checkbox"/>		Economically Inactive Caring Role <input type="checkbox"/>							
Outreach <input type="checkbox"/>		Children's Mental Health Service <input type="checkbox"/>		Crime Prevention <input type="checkbox"/>		Relative <input type="checkbox"/>				Persistent Absentee <input type="checkbox"/>		Economically Inactive Health Issue <input type="checkbox"/>							
YP Housing Provider <input type="checkbox"/>		School Nurse <input type="checkbox"/>		YOT/YOS <input type="checkbox"/>		Concerned Others <input type="checkbox"/>				Apprenticeship/Training <input type="checkbox"/>		Voluntary Work <input type="checkbox"/>							
Referrer Contact Details: NAME/ADDRESS/E-MAIL						Violence Risk/Risk to EB Worker or Others: (Low/Medium/High) (Risk to Peers/Family Workers etc)				Is a SOCIAL WORKER involved? YES <input type="checkbox"/> NO <input type="checkbox"/>									
										If not involved, has a CAF been completed? YES <input type="checkbox"/> NO <input type="checkbox"/>									
Signature of Referrer:						Date Referral sent to Early Break: / /				Name/information of Social Worker/Lead Professional:									