**Referral form**

**The YP Project**

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| **Please complete this referral as fully as possible. Failure to do so will result in a delay in us being able to process the referral.**  |
| **Referrer details** |
| Your name and relationship to the person being referred:  |  | Today’s date: |  |
| Your email address:  |  | Your phone number: |  |
| Please confirm that consent has been gained for this referral:  |  Young Person’s Consent: Yes [ ]  No [ ] Parent Consent: Yes [ ]  No [ ] Please note that we cannot accept referrals without **BOTH** parent and young person’s consent.  |
| Please describe your involvement with the family: |  |
| Please advise the status of any safeguarding measures/child protection plans: |  |
| Is there/has there been CAMHS involvement? |  |
| Is this referral relating to abuse toward parent/carer or intimate partner or both? |  |

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| **Other Professionals Involved** |
| Name  | Phone Number | Email | Organisation & Role (State what members of the family they’re working with) |
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| **Details of young person being referred** |
| Name: |  | D.O.B: |  |
| Email: |  | Phone: |  |
| Support required for engagement (Interpreter, language, literacy, etc):  |  | Address: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Previous criminal convictions, injunctions, cautions or arrests for domestic abuse: |  | Are there ongoing care proceedings? |  |
| Number of Police call outs: |  | Is the YP on Pupil Premium? |  |
| Current criminal proceedings or injunctions concerning domestic abuse: |  |
| What school or college does the young person attend? |  |
| Is the young person at risk of exclusion? |  |
| Is the young person in a relationship? |  |
| Physical Disabilities or Mental Health concerns:  |  (If yes, please describe)  |
| Substance misuse concerns:  |  (If yes, please describe)  |
| Is the client currently engaging in any other behaviour change work or treatment such as counselling, substance misuse treatment, psychiatric treatment, etc? |  (If yes, please describe)  |
| Are there any risks to professionals that you are aware of? |  (If yes please describe)  |

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| **Other Children in the Home** |
| First name  | Surname | D.O.B. | Sex | Living and contact arrangements  |
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| **Referral details** |
| What has led to this referral? Please provide details of known support needs for the family and anything else you think we should know. |
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| Please provide details of all known incidents and risk factors. (Please mention if any incidents led to any police callouts) |
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| Please provide a description of any strengths, interests or positive interactions with the young person. Are there adults/relatives with which they have a positive relationship. If appropriate please provide their contact information as well.  |
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| How did you hear about The YP Project? |
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| **Parent/Carer or Partner of Young Person being referred**  |
| Name: |  | D.O.B: |  |
| Email:  |  | Phone: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Address: |  | Support required for engagement (Interpreter, language, literacy, etc.) |  |
| Physical Disabilities or Mental health concerns:  | (If yes, please describe) |
| Substance misuse concerns:  | (If yes, please describe) |
| Are there any risks to professionals that you are aware of? | (If yes please describe) |
| Has the parent/carer been impacted by DV in the past? Has there been DV in the family?  | (If yes please describe) |
| Please confirm that you have consent to share the person described above’s details.Yes [ ]  No [ ]  |

If there is another parent/carer involved with the young person or family, please give their details below:

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| **Parent/Carer or Partner of Young Person being referred**  |
| Name: |  | D.O.B: |  |
| Email:  |  | Phone: |  |
| Gender:  |  | Sexuality: |  |
| Ethnicity: |  | Religion: |  |
| Address: |  | Support required for engagement (Interpreter, language, literacy, etc.) |  |
| Physical Disabilities or Mental health concerns:  | (If yes, please describe) |
| Substance misuse concerns:  | (If yes, please describe) |
| Are there any risks to professionals that you are aware of? | (If yes please describe) |
| Has the parent/carer been impacted by DV in the past? Has there been DV in the family?  | (If yes please describe) |
| Please confirm that you have consent to share the person described above’s details.Yes [ ]  No [ ]  |

**Please return this form to:** **info@jenkinscentre.org****.**

**Once we have received your referral we will confirm safe receipt via email. Should you wish to send the referral via CJSM to:** **Jenkins.Centre@freeva.cjsm.net**