|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral** |  | | | | | |
| **Name of person taking Referral** |  | | | | | |
| **Name and contact details of Referrer:**  **Address**  **Email**  **Telephone** |  | | | | | |
| **Service Area (Please tick or cross where appropriate)** | | | | | | |
| **Service Area** | | | **North** | **South** | | **Central** |
| Access and Response Team | | |  |  | |  |
| 0 – 25 Disability Team | | |  |  | |  |
| Transitions to Independence | | |  |  | |  |
| Looked After Children | | |  |  | |  |
| Locality Team | | |  |  | |  |
| **Resource Panel Date and Chair:** |  | | | | | |
| **ASSESSMENT (**Please Tick) |  | **Note:** This referral takes about one hour to complete and forms part of the Service. Please request all previous reports be sent prior to referral conversation and arrange sufficient time | | | | |
| **THERAPY (**Please Tick) |  | **Note** This referral takes about 30 minutes to complete. Please request all previous reports prior to conversation. | | | | |
| **Name of Young Person/Child:** |  | | **D.O.B** | |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ethnic Origin (Please circle appropriate)** | | | | | |
| White – British | White – Irish | | | White – Other | |
| Black – British | Black – African | | | Black – Other | |
| Chinese | Mixed – White and Black African | | | Mixed – White and Black Caribbean | |
| Bangladeshi | Pakistani | | | Indian | |
| Asian/Asian British – Indian | Asian/Asian British – Pakistani | | | Asian/Asian British – Bangladeshi | |
| Arabian | Other please specify: | | | | |
| **Child’s Legal Status:** | | | | | |
| Is the Child/Young Person on a disability register? | | | | | Yes / No |
| Is the Child/Young Person subject to a Child in Need Plan | | | | | Yes / No |
| Is the Child/Young Person subject to a CP Plan? | | | | | Yes / No |
| Is the Child/Young Person classed as ‘looked after’ by LA? | | | | | Yes / No |
| Is the Child/young Person Adopted | | | | | Yes/No |
| **Parents/Carers Name(s):** | |  | | | |
| **Home Address and contact details. Telephone Numbers and email.** | |  | | | |
| **BACKGROUND AND REASON FOR REFERRAL:** Current Professional Context, (Charges, Court Orders, Safeguarding etc.) Previous Assessments or Therapeutic Work. Professional views and concerns. | | | | | |
|  | | | | | |
| **FAMILY AND INDIVIDUAL BACKGROUND:** Genogram:including Grandparents and parents, siblings, signs of safety and danger, attachment patterns, trauma and losses, descriptions of child or young person – development. Physical , mental or intellectual disabilities which impact on the child or YP’s wellbeing: | | | | | |
|  | | | | | |
| **CONCERNING BEHAVIOURS:** Details of sexual behaviour; Context of sexual behaviour and risk, previous responses and sanctions including child or YP attitude. Victim details and restorative processes. | | | | | |
|  | | | | | |
| **RESOURCES:** individual and relational. Support, skills, engagement, | | | | | |
|  | | | | | |
| **PROFESSIONAL NETWORK:** | | | | | |
| Social Care | | |  | | |
| Health | | |  | | |
| Fostering or Adoption Agency Staff | | |  | | |
| Education | | |  | | |
| Youth Offending Team (YOT) | | |  | | |
| Voluntary Sector | | |  | | |
| Other | | |  | | |
| **NEXT STEPS:** | | | | | |
|  | | | | | |