REFERRAL FORM

This form is to be completed by the referring agency/social worker. Please complete it with as much detail as possible and when asked to indicate, please tick the appropriate category.

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| **Name:** |  |
| **Address:** |  |
| **Tel No:** |  |
| **D.O.B:** |  |
| **Legal Status:** |  |
| **Name of Parent/s:** |  |
| **Address** |  |
| **Tel No:** |  |
| **Name of Current**  **Carers:** |  |
| **Address:** |  |
| **Tel No:** |  |
| **Religion:** |  |
| **Ethnicity:** |  |
| **Language Spoken:** |  |
| **Reason for Referral:** |  |

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| --- |
| Background Information:  (Please include reasons for care episode, previous placements, family history) |
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| Family Composition:  (Please include all significant relatives in the young person’s life) |
| Surname Forename DOB Relationship |

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| Health Information:  (Please include any ongoing treatment, allergies, illnesses) |
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| Education:  (Please include any current educational provision, attendance, attainment) |
|  |
| **Does the YP have an EHC Plan or in process of EHC Needs Assessment?**  (If yes, please provide a copy of plan)  Yes / No |
| **Contact Arrangements**:  (Please include details of any court orders restricting contact) |
|  |
| Social/Emotional/Personal Development:  (Please include details of any therapy/counselling) |
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| Desired Outcomes: |
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| **Risk Assessment**:  (Please indicate if the child/young person has a history of the following) |
| Self Harming  Offending Behaviour  Drug/Alcohol/Substance Misuse  Violence  Violence/Aggression towards Staff  Child Sexual Exploitation  Challenging Behaviour  Fire Setting  Prostitution  Eating Disorder  If **Yes**, Please give details: |
| Other Relevant Information:  (Please indicate if any of the following are available with this referral and enclose) |
| Other: |

Referral made by:

|  |  |
| --- | --- |
| Name of Social Worker: |  |
| Borough: |  |
| Address: |  |
| Tel No: |  |
| Name of Team Manager: |  |
| Budget Code: |  |
| Address: |  |
| Tel No: |  |
| Emergency Duty  Team Tel No: |  |
| Date of Referral: |  |

Please send completed referral form to:

E-Mail: [jamila.ferron@supportindependence.co.uk](mailto:jamila.ferron@supportindependence.co.uk) / [admin.life@supportindependence.co.uk](mailto:admin.life@supportindependence.co.uk)

Tel: 07534 955 582

Office use only:

|  |  |
| --- | --- |
| Date Received: |  |
| Action Taken: |  |
| Staff Signature: |  |