|  |  |
| --- | --- |
|  | A logo with a star and text  Description automatically generated **Young Person’s Referral Form** |
| **1** | **Essential Criteria for Acceptance of Referral: (if you answer ‘No’ to any of the questions in Box 1, please contact us to discuss further)****\*Is the young person aware of this referral? Yes [ ]  No [ ]  & \*Do they agree to this referral? Yes** **[ ]  No** **[ ]**  |
| **2** | **\*Are the young person’s parents/carers aware of this referral? Yes** **[ ]  No** **[ ]** **(please note: the parental consent form is required for a young person under the age of 13 years)** |
| **3** | **REFERRERS DETAILS** |  |  |
|  | Name: | Organisation: | Role: |
| Address: |
| Contact Tel No: | E Mail Address: | Person to contact in your absence: |
| **4** | **REFERRAL DETAILS -** Tick the relevant referral request.Please record information in as much detail as possible as this helps the service to determine risk levels |  |
|  | **YP SUBSTANCE USE** **[ ]**  |  |
|  | **Substances currently being used.** | **Route- smoke, oral, snort** | **How much - £, bags, cans, bottles** | **How often - daily, 2/7, weekly, binge** |  |
|  |  |  |  |  |  |
|  | **HIDDEN HARM** **[ ]**  |  |
|  | **Is the young person aware of the substance use within the family?** | **What does the impact of the substance use have on the young person?** | **Substances being used** | **Family member using substances / Does the young person have contact with them?** |  |
|  |  |  |  |  |  |
|  | \*Where would the young person like to be seen? | \*Can the young person be contacted at home? Yes [ ]  No [ ]   |  |
|  | \*Are there any risks in visiting the home? Yes [ ]  No [ ]  Please record detail below: | \* Who does the young person live with? |  |
|  | **GROUP** **[ ]**  |  |
|  | **Any details / risks we need to be aware of in group environment?** |  |
|  |  |  |
|  |  |  |
| **5** | **CLIENT DETAILS** |  |  |
|  | Name | Date of birth  | Age |  |
|  | Address | Gender experience / IdentityPronouns used by young person: | Client’s Education Status:Name of school / college:  |  |
|  | Postcode | Young Person’s Contact Tel No: |  |
|  | Ethnicity | Parent/Carer Name & Contact Tel No: |  |
|  | Is the young person receiving mental health treatment? Yes [ ]  No [ ]  Professional working with client: | Does the young person have learning / Disability needs?Please provide details:Is an interpreter required? Yes [ ]  No [ ]  If so, for which language? |  |
| **6** | **\*SAFEGUARDING** |
| **Are there any Safeguarding concerns?** Yes [ ]  No [ ]   **Is the young person on a Child Protection Plan?** Yes [ ]  No [ ]  **€****Is the young person on a Child In Need Plan?** Yes [ ]  No [ ]   **Is the young person a Looked After Child?** Yes [ ]  No [ ]  Social Workers name: Contact details:**Please detail reason for involvement or Safeguarding concerns:**  |
| **7** | **\*EXPLOITATION – CSE /CCE**  |
| **Has a Risk Factor Matrix been completed?** Yes [ ]  No [ ]   **Is the young person on MACE panel?** Yes [ ]  No [ ]  **Risk level on Matrix** Low [ ]  Medium [ ]  High [ ]  CCE [ ]  CSE [ ]  DUAL [ ]  **PLEASE ATTACH RFM WITH REFERRAL FORM**record reasons for completion below: |
| **8** | **\*OFFENDING** |
| Is the young person involved in criminal activity Yes [ ]  No [ ] Is the young person at risk of becoming involved in criminal activity Yes [ ]  No [ ] Is the young person working with the Youth Offending Service Yes [ ]  No [ ]  **Case Manager’s Name:****Please detail offence type/s, & additional information** |
| **\*STRENGTHS AND PROTECTIVE FACTORS\*** |
| Please record what strengths the young person has and the protective factors in place for them:  |
| **\*ADDITIONAL INFORMATION\*****Identified Risks:** **Safeguarding, Risks to home visiting, Risk to worker, Exploitation, overdose, injecting, offending, physical/mental health issues, binge use, & Any Other Relevant Information** |
| Please record any extra information to support the referral: |

**Please submit your referral: STARSYP@mpft.nhs.uk**