|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 / Identity  Pronouns 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**