**SAFE Referral Form**

Please complete **all sections of this form** and return to[**safe@kibble.org**](mailto:safe@kibble.org). We recommend exceeding **no more than 250 words** per section.

If you have any questions please do not hesitate to contact us.

|  |  |
| --- | --- |
| YOUNG PERSON DETAILS | |
| Name |  |
| D.O.B. |  |
| Postcode |  |
| Gender |  |
| Ethnicity |  |
| Local Authority Area |  |

|  |  |
| --- | --- |
| REFERRER DETAILS | |
| Name |  |
| Designation |  |
| Address |  |
| Email |  |
| Telephone |  |

|  |
| --- |
| REASON FOR REFERRAL |
| Please briefly state the reason for the referral including:   * how the young person has been impacted by crime (as a victim and/or a witness) * a summary of the presenting problems; what, where, who with |

|  |  |  |  |
| --- | --- | --- | --- |
| **RELEVANT BACKGROUND** | | | |
| **FAMILY CIRCUMSTANCES**  *Including:* who is the family around the child, description of parenting strengths and difficulties, description of family functioning past and present e.g. health, mental illness, substance misuse, occupation and any care disruptions/residential placements. | | | |
|  | | | |
| **EDUCATION** | | | |
| |  |  |  | | --- | --- | --- | |  | **YES** | **NO** | | Currently in education |  |  | | Currently in mainstream school |  |  | | Difficulties within education/learning |  |  | | | | |
| **MENTAL AND PHYSICAL HEALTH**  Does the young person have difficulties (diagnosis or subthreshold difficulties) in the following areas? | | | |
|  | **YES** | **NO** | **UNKNOWN** |
| Attachment difficulties (including Reactive Attachment Disorder) |  |  |  |
| Post-Traumatic Stress Disorder (incl. acute & complex trauma) |  |  |  |
| Acquired Brain Injury |  |  |  |
| Attention Deficit Hyperactivity Disorder |  |  |  |
| Autism Spectrum Disorder |  |  |  |
| Other Neurodevelopmental Disorder (NOS) |  |  |  |
| Intellectual Disabilities |  |  |  |
| Learning Disorder (e.g., dyslexia, dyscalcula, etc.) |  |  |  |
| Conduct/Oppositional Defiant Disorder |  |  |  |
| Feeding/Eating Disorder |  |  |  |
| Elimination Disorder (difficulty with toileting) |  |  |  |
| Anxiety Disorder |  |  |  |
| Mood Disorder |  |  |  |
| Psychotic Disorder |  |  |  |
| Substance Use Disorder (incl. alcohol) |  |  |  |
| Tic Disorder/Tourettes Syndrome |  |  |  |
| Possible Emerging Personality Disorder |  |  |  |
| Gender Identity Issues |  |  |  |
| [Foetal Alcohol Spectrum Disorder](https://www.bing.com/ck/a?!&&p=1fb5f7c28a3e3cd0JmltdHM9MTY2MDgzMjQzMyZpZ3VpZD04M2E3MWIxZC1hZDg3LTQ5MzEtYjdkNi1mMDI5MDBjMDNmZDMmaW5zaWQ9NTE5Ng&ptn=3&hsh=3&fclid=eb64a8f7-1f00-11ed-8693-7ef7d8cba03a&u=a1aHR0cHM6Ly93d3cubmhzLnVrL2NvbmRpdGlvbnMvZm9ldGFsLWFsY29ob2wtc3BlY3RydW0tZGlzb3JkZXIv&ntb=1) (FASD) |  |  |  |
| Other (please specify): | | | |
| **CRIMINAL HISTORY**  *Including:* previous convictions, ongoing criminal investigations | | | |
|  | | | |
| **OTHER RELEVANT INFORMATION**  *Including*: personal or family involvement in ongoing criminal proceedings, child protection concerns, children’s hearing system involvement, safety concerns, any other information | | | |
|  | | | |
| **HOPES AND EXPECTATIONS**  What do you hope the SAFE project can do for the young person/family/professionals supporting them? | | | |
|  | | | |

|  |  |
| --- | --- |
| **CURRENT SUPPORTS**  Please detail **all current professional supports, including name and email address**.  These details will be used to invite professionals to an initial consultation meeting. | |
| e.g. *John Smith, CAMHS Psychologist,* [*psychologist@camhs.com*](mailto:psychologist@camhs.com) | |
| Is there an allocated social worker?  *If yes; include contact details above* | Yes / No |

|  |  |
| --- | --- |
| Are the young person/family aware of this referral? *\*we recommend they are wherever possible* | Yes / No |
| If YES, please provide  parent/carer contact details: |  |
| What are their hopes/expectations/worries? |  |

Where did you find out about Safe? (tick all that apply)

|  |  |
| --- | --- |
| Social media e.g. Twitter |  |
| Email |  |
| Website |  |
| Word of mouth |  |
| Other (please specify): |  |

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Please indicate here if you’d like to receive information about the service’s development, events and research: |  |  |

|  |
| --- |
| ANY OTHER INFORMATION |
|  |

By submitting this form, you agree that:

* You are authorised to share this information with the SAFE Project within the Kibble Group.
* You have discussed this with the young person and/or family concerned where possible.

Please see our [Privacy Policy](https://www.kibble.org/privacy-policy/) on our website for information about how we will handle this information.

The SAFE Project recommends that you submit this form via encrypted email to [safe@kibble.org](mailto:safe@kibble.org) or by Recorded Delivery post if submitting it via hard copy, or in line with your organisational policy.

The postal address is:

SAFE Project

Kibble

Goudie Street

Paisley

PA3 2LG

**Following receipt of your referral we will make contact with you to either get further information, if required, and/or arrange a consultation in the first instance.**