**Referral Form**

**Interventions for Vulnerable Youth**

**Instructions:**

1. Please **complete all sections of the form in full** and be as specific as possible with the information you give**.**
2. The form should be **typed** or **handwritten clearly in black ink**.
3. Please **DO NOT** attach any additional reports/information to this referral form. All appropriate information should be summarised within this form or discussed at the consultation.

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| **DEMOGRAPHIC INFORMATION** |
| Name of Young Person:  |
| Young Person’s Postcode Sector (i.e., AB25): | Birth family postcode: |
| Age and Date of Birth: | Gender: |
| Ethnicity: | Local Authority of Young Person: |
| Details of any legal orders or conditions: |

**Please note the main areas of help, support, or advice you are seeking from a consultation:**

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| 1: |
| 2: |

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| **Please provide detail on current areas of concern. This should include specific details of any risk-related incidents, e.g. violence, harmful sexual behaviour, absconding, or deliberate or accidental self-harm.** |
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| **Please provide a summary of 1.) the young person's developmental history and 2.) current family and/or care arrangements.** |
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| **Please provide details of any mental health care that the young person has received. This should include any neurodevelopmental assessments, any ongoing CAMHS input, any diagnoses, and any speech/language/communication needs.** |
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| **Please add any additional information you consider important in this referral if not covered by the above sections, including any protective factors.** |
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| **REFERRER AND OTHER CONTACT DETAILS** |
| Name of Referrer: | Designation: |
| Address: |
| Telephone number: | Email address: |
| Signed: | Date: |
| Name and contact number of manager/supervisor: |

**Please indicate here if you’d like to receive information about the service’s development, events and research** [ ]

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| **Other Agencies or Key Professionals Currently Involved** **(please include all professionals you would like to be involved in consultation)** |
| Agency | Contact Name and Designation | Email Address | Telephone Number | Will participate in consultation (Y/N) |
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By submitting this form, you agree that:

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

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

**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.**