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| **PLEASE NOTE:** * A separate referral form is required for each child referred.
* We will be unable to accept referral forms which are not FULLY completed.
 | OFFICE USE ONLY |
|  | Child’s Forename: |       |
|  | Child’s IAPTUS Identifier: |       |
| Please return this form to afcbsmdd.adminchanginglives@nhs.net |
| **The Referrer:**  |
| Agency/School: |       |
| Name: |       | Role: |       |
| Address: |       |
| Postcode: |       | Telephone Number: |       |
| Email Address: |       |  |  |
| How long have you known the child/young person: |  |
| Has the family had an Early Help Assessment completed in the last 12 months?  | Yes [ ]  If yes, please attach with the referralNo [ ]  |
|   |  |  |  |
| **The Child/Young Person:**  |
| **Forename(s):** |       | **Surname:** |       |
| Likes to be called: |       | **Date of Birth:** |       |
| Identifying gender |       | Preferred pronouns |       |
| Child Protection: | Yes: [ ]  No: [ ]  | Child in Care/Entering Care: | Yes: [ ]  No: [ ]  |
| Child in Need: | Yes: [ ] No: [ ]  | NHS Number (if known): |       |
| Disability:*Select all that apply.* | ADHD: [ ]  ASD: [ ]  Hearing: [ ] Learning Difficulties: [ ] Mobility: [ ] Sight: [ ] Speech: [ ] Other:       |
| Address: |       |
| Postcode: |       |  Mobile Number: |       |
| Email Address: |   | EthnicityChoose an item. |
| Preferred method of communication: | Telephone:[ ]  Email: [ ]  Text: [ ]  |
| Name(s) of person(s) with parental responsibility:*Please ensure that full contact details are included below.* |       |
|  |
| **The Resident Parent(s) or Carer(s):**  |
| Name(s): |       | Relationship(s): |  |
| Mobile Number: |       | Landline Number: |       |
| Email Address (please include wherever possible): |       |
| Preferred method of communication: | Telephone:[ ] Email: [ ]  Text: [ ]  |
| **Significant Members of the Household/Family Network:** *e.g. non-resident parent, step-parents, grandparents etc. Contact details only required where these are different from those given for the Child/Young Person above* |
| Name: | Relationship to child: | Address or Email address: | Telephone Number: |
|       |       |  |      |
|       |       |       |       |
| **Other children living in the household:** |
| Name child 1 | DOB Child 1 | Name Child 2 | DOB Child 2 |
|  |  |  |  |
| Name child 3 | DOB Child 3 | Name Child 4 | DOB Child 4 |
|  |  |  |  |
| **Are there any further Issues about the Child/Young Person or the Family that we need to be aware of:** |
| What is the families preferred language: |  |
| Is an interpreter required for communications in English: |  |
| Problems with literacy: |       |
| Physical, Sensory or Learning Difficulties: |       |
| Issues relating to ethnicity or culture: |       |
| Issues relating to gender or sexuality: |       |
| Any health and safety issues or current risks in the home: |       |
| **GP/Medical Practice (if not referrer):** *As our service is funded by Derbyshire and Derby City CCG we need details of the young person’s registered GP/Medical Practice in order to confirm their eligibility for the service.* |
| GP Name (if known): | **Medical Practice:** | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
| **Significant Medical Professionals involved (if not referrer):** *Please list any other significant medical professionals involved with the young person e.g. paediatrician, CAMHS, School Health Service etc.* |
| Name: | Agency: | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |  |  |  |
| **School (if not referrer):**  |
| School: |       |
| Address: |       |
| Postcode: |       | Telephone Number: |       |
| Email Address: |       |  |  |
| Attendance: | Attending: [ ] Not Attending: [ ] Excluded: [ ]  |
| **Significant Contacts:** *Please list any significant contacts within school e.g. Head Teacher, Head of Year, Class Teacher, Pastoral Manager, SENCO etc.* |
| Name: | Role: | E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|   |
| **Other Significant Agencies:** *Please give details of any other relevant agencies providing support to the family or young person not already listed above e.g. Social Worker, Other Support services etc.* |
| Name: | Agency: | Address or E-mail Address: | Telephone Number: |
|       |       |       |       |
|       |       |       |       |
|  |  |  |  |
| **Current Issues for the Child:** *Please select all that apply and give details below e.g. how this impacts on child’s life, how long for?.* |
| Difficulty making relationships: |[ ]  Help managing/understanding child: |[ ]  Eating/Body Image: |[ ]
| Reaction to separation and loss: |[ ]  Mild/moderate anxiety symptoms: |[ ]  Problems attending school: |[ ]
| Difficulty managing behaviour: |[ ]  Friendships/bullying issues: |[ ]  Problems at school: |[ ]
|  |  | Self-Harm: |[ ]  Other: |[ ]
| Please give details: |       |  |
| **Current Issues for the Family:** *Please select all that apply and give details below.* |  |
| Bereavement: |[ ]  Domestic Abuse: |[ ]  Family Violence/Conflict: |[ ]
| Separation/Divorce: |[ ]  Loss: |[ ]  Homelessness: |[ ]
| Parental Drug/Alcohol Issues: |[ ]  Parental Mental Health (medicated): |[ ]  Poor Housing Conditions: |[ ]
| Parental Learning Difficulties: |[ ]  Long term physical health issues: |[ ]  ACEs: |[ ]
|  |  |  |  | Other: |[ ]
| Please give details: |       |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |
| **Historic Issues for the Family:** *Please select all that apply and give details below.* |  |
| Bereavement: |[ ]  Domestic Abuse: |[ ]  Family Violence/Conflict: |[ ]
| Separation/Divorce: |[ ]  Loss: |[ ]  Homelessness: |[ ]
| Parental Drug/Alcohol Issues: |[ ]  Parental Mental Health (medicated): |[ ]  Poor Housing Conditions: |[ ]
| Parental Learning Difficulties: |[ ]  Long term physical health issues: |[ ]  ACEs: |[ ]
|  |  |  |  | Other: |[ ]
| Please give details: |       |  |
| **Tell us about the child**. *Include a description of difficulties, measures taken to address them, any sufficient history, other services involved (currently or previously) and the impact these have had.* |  |
|       |
| **What help are they asking for?** |  |
|       |
| **Data Protection and Consent:** *Please ensure that you are able to answer “yes” to all the following statements appropriate to the child’s age on the date of referral. Unfortunately if you are not able to answer “yes” to any of these we will be unable to accept or process the referral.* |
|  |
| **All referrals** | ***Yes*** |
| Action for Children is part of a community triage process with other services across Derbyshire and Derby city to ensure children and families receive the most appropriate support from the right service. These other services are from Health, Social Care, Education and the Voluntary Sector. Please tick to say you have discussed this with parents and they give consent for us to share the information contained within this referral form with these agencies. Please leave blank if they do not consent to this. |[ ]
| **Children aged 4 years and under**: | ***Yes*** |
| The parent/carer has given their consent for a referral to Action for Children to be made and that this will involve direct work with the whole family system. |[ ]
| The parent/carer is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children to use these to contact them to discuss the referral in more detail. |[ ]
| **Children/Young People aged 5 to 15**: | ***Yes*** |
| The child/young person is aware of the referral and what the service will mean to them.  |[ ]
| The parent/carer has given their consent for a referral to Action for Children to be made and that this will involve direct work with the whole family system. |[ ]
| The parent/carer is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children to use these to contact them to discuss the referral in more detail. |[ ]
| **Young People aged 16 and over**: | ***Yes*** |
| The young person is aware of the referral, what the service will mean to them and has given their consent for it to be made.  |[ ]
| The young person is aware of the personal details contained in this form (such as names, dates of birth, contact details and referral information) and has given their consent for Action for Children and The Derbyshire Federation for Mental Health to use these to contact them to discuss the referral in more detail. |[ ]
| **Referrers Agreement** |  |
| By signing this document, you are confirming that you have accurately completed this form to the best of your ability and have answered “yes” to the appropriate data protection and consent statements above. | Signed: |       |
|  | Print Name: |       |
|  | Date: |       |
| *Please note referrals submitted electronically do not need to be printed and signed. We will take submission by email as electronic signature assuming name and date are completed above.* |
|  |