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**Barnardos Young Peoples and Families Team**

**Independence Project**

**Service Request Form**

Name of person making service request:

Agency:

Contact details:

**Name of young person:**

**Date of birth: Age:**

**Address(including postcode):**

**Telephone number:**

**Gender: Male 🞎 Female 🞎 Non – Binary 🞎 Prefer not to say 🞎**

**Care status: Yes 🞎 No 🞎 Historical 🞎**

**Ethnicity:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| White- British |  | White- Irish |  | White – other background |  | White – Eastern European |  |
| Mixed – White/Black Caribbean |  | Mixed – White/Black African |  | Mixed- Any other background |  | Asian - Indian |  |
| Asian - Pakistani |  | Asia - Bangladeshi |  | Asian/British – other background |  | Black/Caribbean |  |
| Black/African |  | Black/other background |  | Chinese |  | Other- please state |  |

**Disability**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Autistic Spectrum Disorder |  | Behaviourally based disability |  | Learning Disability |  | Mental Ill Health – lasting more than 12 months |  |
| Physical Impairment |  | Hearing impairment |  | Sight impairment |  | None |  |

**Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

None Practised:🞎 Prefer Not to say 🞎

**Sexual Orientation:**

Gay F/M: 🞎 Heterosexual: 🞎 Prefer not to say 🞎

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professionals currently involved:**

Name Agency email address telephone

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**GP surgery name & address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there any current risks in working with this young person? Yes 🞎 No 🞎**

**If Yes Please specify**:……………………………………………………………………………………………………

……………………………………………………………………………………………………………….

**In Education: Yes 🞎 No 🞎**

**If Yes: name and contact details of school**……………………………………………………………………

**Reason for Referral/What support do you require?**

**Signed: Date:**

Where possible please can the young person sign the form to give consent to the referral

**Signed: Date:**

**Return form to:** [**BYPFT@barnardos.org.uk**](mailto:BYPFT@barnardos.org.uk)