**Barnardo’s Resilience Service** Referral Form

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| **Has the Parent/Carer consented to this referral**  **\*\*Please ensure the young person and/or parent/carer is made aware of this referral before sending .** | | | Yes  No |
| **Young Person’s Details** | | Date of referral: | |
| Name: | | D.O.B: Age: | |
| Gender: | Religion: | Ethnicity: | |
| Contact address:  Postcode: | | **Parent/Carer contact details:** | |
| Name:  Home Tel:  Mobile number:  E-Mail address: | |
| **Does the young person have any of the following:** | | **Agencies currently involved with the young person or family:** | |
| Disability/SEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Language Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  A medical condition Y  N  If yes, please give details below:  On medication Y  N  If yes, please give details below: | | Children’s Social care  Early Help  YAZ (Youth Action Zone)  Homestart  Catch 22  Listening Ear  YMCA Listening Service  CYPMHS (Children & Young People Mental Health Service)  Barnardos BOSS  MHST (Mental Health Support Teams)  Other service/s:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Please tick the boxes below that currently relate to this young person (if applicable) :-** | | | |
| Looked After Child  Child in Need  On a Child Protection Plan  Young Carer | | | |
| GP Name & Address:    YP NHS Number: | | Name of Referrer:  Tel Number:  Email Address:  Relationship to young person:  School attending:  School Year Group: | |
| **Main reason for referral** – e.g. Bereavement, Anxiety, Health & Wellbeing, Family & Peer Relationships, Self Confidence, School, Trauma – **and how does this present?** | | | |
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| **What are you worried about? How is this impacting their daily life?**  **What are your hopes for this child?** | | | |
|  | | | |
| **What is working well? Please include any identified strengths and support systems** – e.g. hobbies, school, friendships, family. | | | |
|  | | | |
| **Which Resilience Service do you think is most suitable?** | | | |
| Group Work/Workshop  1:1 Brief Therapy  Parent Consultation | | | |
| Do you consent to transfer of referral information to a partnership agency if assessed as more appropriate for the young person’s needs? Yes  No | | | |
| Please email completed form to: [sthresilience@barnardos.org.uk](mailto:sthresilience@barnardos.org.uk) | | | |