**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?** |
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| **What is working well? Please include any identified strengths and support systems** – e.g. hobbies, school, friendships, family. |
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| **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 |