|  |  |  |  |
| --- | --- | --- | --- |
| 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 involved with young person: | |
| Disability/SEN/  Language Needs  A medical condition Y  N  If yes, please give details  On medication Y  N | |  | |
| GP Name & Address:    YP NHS Number: | | Name of Referrer:  Tel Number:  Email Address:  Relationship to young person:  School YP attends: | |
| Please tick the relevant boxes below that currently relate to this young person (if applicable) :-  Looked After Child  Child in Need  On a Child Protection Plan Young Carer | | | |
| Main reason for referral – (e.g. Bereavement, Behaviour, Health & Wellbeing, Family & Peer Relationships, Self Confidence, School, Trauma). | | | |
|  | | | |
| Additional Information - Please provide as much detail as possible including history/background; presenting difficulties and behaviours and how this is impacting the child/young person. Please also include strengths. | | | |
|  | | | |
| Which service would you like your young person to access? | | | |
| 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) | | | |