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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 involved with young person: |
| Disability/SEN/Language NeedsA 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 |