REFERRAL FORM

Request for a Service for Child/Young Person

Please note: All Referral Forms must be completed by the professional referring the case and signed by them, the young person and parent/carer before they can be processed. Please complete all sections of the form.

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|  |  | |  |  | |  |  |
|  | Child’s details | | |  | |  |  |
|  |  | | |  | |  |  |
|  | Child’s name |  | | | Ref:  (leave blank) |  |  |
|  |  | |  |  | |  |  |

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|  |  | |  |  | |  |  |
|  | Address: |  | | | | |  |
|  |  |  | |  |  | |  |
|  | Town: |  | | Postcode: |  | |  |
|  |  |  | |  |  | |  |
|  | Date of birth: |  | | Gender: |  | |  |
|  | | | | | | | |
|  | Ethnicity: |  | | Preferred Pronouns: |  | |  |
|  |  |  | |  |  | |  |
|  | Nationality: |  | | Faith: |  | |  |
|  | | | | | | | | |
|  | Preferred language: |  | | Interpreter required: |  | |  |
|  | | | | | | | |
|  | Literacy support: |  | | Legal Status: |  | |  |
|  |  |  | |  |  | |  |
|  | Outline any disabilities: | |  | | | |  |
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| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  |  | |  |  |
|  | Child’s Contacts | | |  | |  |  |
|  |  | |  |  | |  |  |
|  | School/College: |  | | | | |  |
|  |  |  | |  |  | |  |
|  | Address: |  | | Town/Postcode: |  | |  |
|  |  |  | |  |  | |  |
|  | Contact name: |  | | Telephone: |  | |  |
|  |  |  | |  |  | |  |
|  | Name of GP: |  | | Telephone: |  | |  |
|  |  |  | |  |  | |  |
|  | Address: |  | | | | |  |
|  |  |  | |  |  | |  |
|  | Town: |  | | Postcode: |  | |  |
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|  | Details of parents/carer with whom the child/young person is living | | | | | |  |  |
|  |  | |  | |  | |  |  |
|  | Names: |  | | | Relationship: |  | |  |
|  |  |  | | |  |  | |  |
|  | Telephone: |  | | | Mobile: |  | |  |
|  |  |  | | |  |  | |  |
|  | Name of parent/guardian:  (if different from carer with whom child is living) | | |  | | | |  |
|  |  |  | | |  |  | |  |
|  | Do they have parental responsibility? (if not who does?) |  | | | | | |  |
|  | | | | | | | | |
|  | Address (if different from child): |  | | | | | |  |
|  |  |  | | |  |  | |  |
|  | Postcode (if different from child): |  | | | Email: |  | |  |
|  |  |  | | |  |  | |  |

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|  |  | |  |  | |  |  |
|  | Details of referrer | | |  | |  |  |
|  |  | |  |  | |  |  |
|  | Name: |  | | Agency: |  | |  |
|  |  |  | |  |  | |  |
|  | Address: |  | | | | |  |
|  |  |  | |  |  | |  |
|  | Postcode: |  | | Telephone: |  | |  |
|  |  |  | |  |  | |  |
|  | email: |  | | Date of referral: |  | |  |
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|  | Members living at the same address as child/YP | | | | | | (Please include relationship to referred child) | | | |  |
|  |  | |  | | | | |  | |  |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: | SUBJECT/Referred Child | |  |
|  |  |  | | | | | |  |  | |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Name: |  | | | | | | Gender: |  | |  |
|  |  |  | | | | | |  |  | |  |
|  | Date of birth: |  | | Age: |  | | | Relationship: |  | |  |
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|  | Other agencies involved (please tick) | | | | | | | |  | | | |  | | |  | |
|  |  | | | | |  | | |  | | | |  | | |  | |
|  | CYPS: |  | Police: |  | Health: | |  | Mental Health: | |  | | Other (please state): | |  |  | |
|  |  | |  | | | | | |  | |  | | | | |  | |
|  | Please give names and contact details: | |  | | | | | | | | | | | | |  | |
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| Details of sexual abuse | | | | | | |  | | | | | | | | |  | | | | | |  |
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| To whom was the sexual abuse first reported? | |  | | | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | |  | | | | | |  | | | | | | | | |  |
| Who undertook the investigation? (please tick) | | CYPS: | | |  | Police: | | |  | | | Date of investigation: | | | | | |  | | | |  |
|  | |  | | | | |  | | | | | |  | | | | | | | | |  |
| Outcome of the investigation: | |  | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Which Police force and contact: | |  | | | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | |  | | |  | | | | | | | | |  |
| Has there been a Child Protection case conference? | | | | | | | | | | Yes: | | | |  | | | No: | | |  | |  |
|  | |  | | | | | | | |  | | |  | | | | | | | | |  |
| If yes, category: | |  | | | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | |  | | | | | |  | | | | | | | | |  |
| Outline the exact nature of the abuse?  E.g. vaginal rape, touching breasts, anal rape, masturbation, made to watch others having sex | |  | | | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | |  | | | | | |  | | | | | | | | |  |
| Age of child/young person when abuse started: | | | | | |  | | Age of perpetrator at time of abuse: | | | | | | | | | | | | |  |  |
|  | | | | | |  | | | |  | | |  | | | | | | | | |  |
| Relationship of child to perpetrator: | | | |  | | | | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | |  | | |  | | | | | | | | |  |
| Does the parent/carer believe the child/YP? | | | | | | Yes: | | |  | | No: | | | |  | | | |  | | |  |
|  | |  | | | | | | | |  | | |  | | | | | | | | |  |
| Does the child/YP or any member of the family have contact with the abuser? | | | | | | Yes: | | |  | | No: | | | |  | | | |  | | |  |
|  | |  | | | | | | | |  | | |  | | | | | | | | |  |
|  | If yes, please give details: | | | | | | | | | | | | | | | | | | | | |  |
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|  | Symptoms and behaviour | | |  | |  |  |
|  |  | |  |  | |  |  |
|  | Child/Young Person’s symptoms and behaviours: |  | | | | |  |
|  |  |  | |  |  | |  |
|  | How do you think the service can help the Child/Young Person and the family? |  | | | | |  |
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|  |  | | |  | | | | | | | | | |  | | |
|  | Details of Family Court proceedings:  (including custody and contact issues, application for Care Orders and dates, if appropriate) | | |  | | | | | | | | | |  | | |
|  |  | | |  | | | | | | | | | |  | | |
|  |  | | |  | |  | | | | | |  | | | | |
|  | In your professional opinion, is the Child/YP safe and supported enough to be able to attend therapy sessions where there is a likelihood of deteriorating behaviour during the process? | | | | | | Yes: |  | | No: |  | |  | | |  |
|  |  |  | | |  | | | |  | | | | | | |  |
|  | Is the Child/Young Person willing to attend sessions? | | | | | | Yes: |  | | No: |  | |  | | |  |
|  |  |  | | |  | | | |  | | | | | | |  |
|  | Has the child/young person been referred to the project in the past? | | | | | | Yes: |  | | No: |  | |  | | |  |
|  |  | | | |  | | | |  | | | | | | | |
|  | Is the Child/Young Person related or in any way connected to any child/young person who has been referred to this project? | | | | | | Yes: |  | | No: |  | |  | | |  |
|  |  | | | | | | | | | | | | | | |  |
|  | If yes, please give details: | | | | | | | | | | | | | | |  |
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In signing this referral, you are consenting to Brave Futures setting up a case file, and processing the referral in order to be considered for receiving a service from us. You are also giving consent for us to contact other professionals who are, or have been, involved with the young person or yourselves (for the purpose of sharing information), and you are also agreeing to us undertaking a risk assessment, should this be necessary. You are also consenting to Brave Futures securely storing and holding onto personal information.

In signing this referral form you also understand that Brave Futures do not hold case responsibility at any time.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  | Signature of referrer: |  | Date: |  |  |
|  |  |  |  |  |  |
|  | Signature of Young Person agreeing to referral: |  | Date: |  |  |
|  |  |  |  |  |  |
|  | Signature of Parent/Carer agreeing to referral: |  | Date: |  |  |
|  | A signature from a parent/carer who holds parental responsibility is required for all referrals. | |  |  |  |
|  |  |  |  |  |  |

PLEASE ATTACH RELEVANT REPORTS AND CASE CONFERENCE MINUTES

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| PLEASE ATTACH RELEVANT REPORTS AND CASE CONFERENCE MINUTES |

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| --- | --- | --- | --- |
| Please make sure all the boxes below are checked before submitting the referral to Brave Futures. If you answer no to any of the questions, we may not be able to accept the referral. |  |  |  |
|  |  |  |  |
| There has been some form of disclosure of sexual abuse by the child or young person and the abuse has been reported to the police and or CYPS. |  |  |  |
|  |  |  |  |
| The child or young person is under the age of eighteen at the time of referral. |  |  |  |
|  |  |  |  |
| The child or young person does not have contact with the abuser, except where this cannot be avoided e.g. school/college etc. |  |  |  |
|  |  |  |  |
| The child or young person lives in an area for which we are funded, currently Suffolk or Norfolk. |  |  |  |
|  |  |  |  |
| The referral form has been hand signed by the referrer, parent/carer and the child or young person. |  |  |  |
|  |  |  |  |
| Please also ensure that you have provided information about the nature of the abuse. |  |  |  |
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| --- | --- | --- | --- |
| Please return form to: | Brave Futures | |  |
|  |  |
|  | 333 Felixstowe Road | |  |
|  | Ipswich |  |  |
|  | Suffolk |  |  |
|  | IP3 9BU |  |  |
| Contact details: |  |  |  |
|  |  |  |
| Telephone: | 01473 353355/01603 558205 |  |
|  | Email: | admin@bravefutures.org |  |
|  | Website: | www.bravefutures.org |  |
|  |  |  |  |