

Referral Form

Please double click on grey boxes to check where appropriate

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is the referral for | Young Persons Advocacy Worker | | Family worker | | Both |
| DATE OF REFERRAL |  | | | | |
| Child’s Full Name |  | | | | |
| Preferred Name: |  | | | | |
| DOB |  | CHI No: ( If Known) | | | |
| Address |  | | | | |
|  | | | | |
|  | | | | |
| Postcode |  | | | | |
| Tel No: |  | | | | |
| Email: |  | | | | |
| Additional Need (Required) | Medical Condition (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Undergoing Assessment  ASD  ADHD  Global Development delay  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| School/ Nursery name and address and contact person |  | | | | |
| Child Protection Register | YES  NO | Is this referral a result of a TATC or CYPP Meeting | | YES  NO | |
| Has a CAMHS referral been rejected | YES  NO |  | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Carer | Role in child/young person’s life | Main Carer | Contact No | Contact email |
|  |  | Y/N |  |  |
|  |  | Y/N |  |  |
|  |  | Y/N |  |  |

Other Children in Family

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of child | M/F | Date of Birth/Estimated Due Date | Additional support Need | | Child Protection Register | | Do they reside in same property | |
| YES | NO | YES | NO | YES | NO |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

*(Please enclose extra sheet for any additional children)*

|  |  |  |
| --- | --- | --- |
| Other Agencies Involved | Name | Tel/email details |
| Family Doctor |  |  |
| Health Visitor |  |  |
|  |  |  |
| Voluntary Organisations? e.g. Barnardos/ ADHD Group |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please add any relevant background information

|  |
| --- |
|  |

What type of Support are you looking for?

|  |  |
| --- | --- |
| Please Check | Support Required |
|  | Advocacy support at school meetings |
|  | Advocacy support at health appointments |
|  | Advocacy support to have my own voice heard |
|  | Support to understand and manage behaviours |
|  | Wellbeing, Emotional support and a listening ear |
|  | Reduce feelings of Isolation and loneliness |
|  | Build, maintain or repair relationships with my peers and/or other agencies |

Please give reason for referral

|  |
| --- |
|  |

How would you best like to receive this support?

|  |  |
| --- | --- |
| Please Check | Support Options |
|  | 1:1 Support – Face to face meetings with a worker and visits to your home/ School/ community |
|  | Virtual Support - Telephone Calls, Texts, What’s App support, Video calls and regular contact |
|  | Peer Group support – Meeting and linking in with other parents in your community and supporting each other |
|  | Decider Skills Workshops (virtual) – Workshops to support and manage behaviours, distress and anxiety |
|  | Other: Please Specify |

As a result of support from Parent to Parent what would you like to see?

|  |  |
| --- | --- |
| Please Check | Support Options |
|  | Parents and Young People feel supported to improve their well-being |
|  | Parents and Young People feel supported to improve their mental health |
|  | Parents and Young People feel less isolated and part of their community |
|  | Parent(s) /Young people have gained an understanding and feel more able to meet child’s/children’s/their own additional support needs |
|  | Parents and Young People feel listened to and their voice is being heard through Advocacy Support |
|  | Parents and Young People have attended/worked through the Decider Skills |
|  | Parents and young people have been supported to manage and understand their own behaviours / communication. |
|  | Parents and Young People have a better understanding of statutory and voluntary support available to them. |
|  | Parents and Young People feel supported in building and maintaining positive relationships with statutory services |

Are there any Health and Safety issues or relevant information we need to consider prior to a home visit?

|  |
| --- |
|  |

Third Party Referral

Have you discussed this referral with the family/young person prior to completing this form? YES  NO

Do you hold consent to share this data with Parent to Parent? YES  NO

We will be acknowledging receipt of this referral with this family, and will be requesting consent to hold their data in line with our Privacy notice which can be found on our website: <https://parent-to-parent.org/privacy-policy/>

This form will be held in confidence but may be shown to the family if requested.

|  |  |
| --- | --- |
| Name: |  |
| Agency: |  |
| Tel No: |  |
| E-Mail: |  |
| Referrers Signature: |  |
| Date: |  |

OR

Self-Referral

Consent: By providing us with your personal information you consent to the collection and use of that information for the purposes and in the manner described in our Privacy Policy. This can be found on our website: <https://parent-to-parent.org/privacy-policy/>

|  |  |
| --- | --- |
| Name: |  |
| Relationship to child: |  |
| Date |  |
| By signing I consent to Parent to Parent holding the above data.  Referrer’s signature |  |

Please return your completed form to: Parent to Parent, Ardler Clinic, Turnberry Avenue, Dundee DD2 3TP or email to [admin@parent-to-parent.org](mailto:admin@parent-to-parent.org)

|  |  |
| --- | --- |
| **For office use only** | |
| Date of request to parent for consent (If applicable) |  |
| Date parent consent given |  |
| Date of request to parent for GDPR (if applicable) |  |
| Date GDPR consent given |  |