Initial Referral Form

NOTE: If have problems completing form online try Adobe Acrobat Reader

Part 1 - Information about the Young Person

First Name(s)		Surnames(s)	

DOB		Gender	
Age		School/Preschool	
NC Year Group		GP Practice	
Ethnicity		If other please state	

Name of parent/carer		Home address	

Parent/Carer Email		Parent/Carer main telephone	

Details of Referrer

Referrer Name		Address	
Job Title			
Agency			
Email		Main telephone	

Current family situation and concerns in school

Comment here

Family

Name	Relationship	Address if different to above	DOB Children only	Gender Children only	School Children only

Part 2 - Other Agencies Involved Please give details details and include other information

Agency/Link Name	Contact Details	Date	Detail of Involvement
Is this young person known to Social Care?		Yes (If so then CP/CIN?	

Risk Factors Please tick if any of the following factors affect this child or young person

	Present		Present
Alcohol		Behavioural Difficulties	
Anxiety		Known to CAMHS	
Attention Deficit Disorder		Child Exploitation	
Autism		Depression/low mood	
Domestic Abuse		School absence <90%	
Drugs		School absence anxiety	
Exclusion from school		Self-Harm	
Family functioning		Sensory Impairment	
Female Genital Mutilation		Suicide Attempts	
Learning Difficulty		Unemployment (adult)	
Medical issues		Youth Offending	
Physical Disability		At risk of offending	
Radicalisation		Young Carer	
Risk to Others		16/17 Homelessness	
Other (please state)		Honour-based violence	

Latest Academic Information

Reading Age	
Spelling Age	
Maths Level	
English Level	
Science Level	
Other information including options chosen at GCSE if applicable:	

******IMPORTANT PLEASE ATTACH LATEST ACADEMIC REPORT and RISK ASSESSMENT******

(NB we are unable to process the referral without these documents)

Special Educational Needs

Does your child have an Education Health Care Plan?
If so, then please enclose a copy.
Does your child have any current / pending diagnoses?
Any medication?:

Child/Young Persons Questionnaire

Name		Date	

How did you feel last week? Tick box that best descrtibes your feeling

		Not at all	On one day	On a few days	Most days	Every day
a	I felt happy					
b	I felt sad					
c	I enjoyed my school work					
d	I had no-one to play with/hang out with					
e	I had lots of energy					
f	I kept waking up in the night					
g	I got on with my friends and family					
h	I felt good about myself					

Did anyone help you answer these questions?

If yes, please write the name of the person that helped you:

Name of referrer	
Date	