

**Referral Form (Adults & C&YP)**

Your Emotional Support Service 23 Carter Street, Uttoxeter, Staffordshire, ST14 8EY

 01889 567 756 / 07394 979 768 hello@yess.uk www.yess.uk

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| ***Children & Young People Referrals Only (please complete, if not fully completed the referral cannot be accepted, thank you for your assistance).*** |
| ***Have you gained consent from the parent or carer/child about this referral?***  | ***0 Yes, they agree******0 No, I have not asked them*** |
| ***Does the child/young person have Frazer competency?*** | ***YES NO*** |
| ***Does the parent or carer/child consent to YESS storing their data? (a copy of our privacy policy is on our website or can be requested by email to hello@yess.uk)*** | ***YES NO*** |
| ***Does the parent or carer/child consent to YESS contacting them for marketing & Development purposes? (THIS CONSENT CAN BE WITHDRAWN AT ANYTIME)*** | ***YES NO*** |
| ***IF YES, HOW WOULD THE PARENT/CARER/CHILD LIKE US TO CONTACT THEM?*** | ***PHONE EMAIL*** |
|  |  |

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| ***Adult Referrals Only (please complete, if not fully completed the referral cannot be accepted, thank you for your assistance).*** |
| ***Does the client consent to YESS storing their data? (a copy of our privacy policy is on our website or can be requested by email to hello@yess.uk)*** | ***YES NO*** |
| ***Does the Client consent to YESS contacting them for marketing & development purposes?*** ***(THIS CONSENT CAN BE WITHDRAWN AT ANYTIME)*** | ***YES NO*** |
| ***If yes, how would the client like us to contact them?***  | ***PHONE EMAIL*** |
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| **Client Name:** **Client Address:** | **DOB:** **Age:**  |
| **Gender:** **Ethnicity:** |  |  |  | **GP Surgery:**  |

**C&YP REFERRAL: PLEASE COMPLETE BOTH PARENT DETAILS IF SEPARATED AND PR IS GIVEN TO BOTH**

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| --- | --- | --- |
| **Parent/Carer Name:** | **Relationship** |  |
| **School:**  |
| **Tel** |  | **Mob** |  | **E-mail** |  |
| **Parent/Carer Name:**  | **Relationship** |  |
| Address (if different from above) |
| **Tel** |  | **Mob** |  | **E-mail** |  |

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| --- | --- | --- | --- |
| **C&YP Referrals only** | **Yes** | **No** | **Details**  |
| Are there current safeguarding concerns? |  |  |  |
| Please indicate first language  |  |  |  |
| Is there a physical, sensory or learning disability? |  |  |  |
| Are there issues relating to ethnicity or culture? |  |  |  |
| Are there issues relating to gender or sexuality? |  |  |  |
| Other: Please indicate |  |  |  |
| Other professionals involved with family |  |  |  |

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| **Please provide a reason for the referral, please also provide an overview of any difficulties and any areas of risk: (To be completed for ALL Referrals C&YP and Adults)** |

**MAIN ISSUES – Please tick all that apply**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Self Harm |  | Family Breakdown/Relationship |  | Tics |
|  | Anxiety |  | Neglect or Abuse |  | ADHD |
|  | Low Mood |  | Behavioural |  | Attachment Difficulties  |
|  | Suicidal Thoughts |  | Domestic Violence |  | Substance Misuse |
|  | Loss or Bereavement |  | Issues Around Sexuality |  | Soiling |
|  | Bullying |  | Pregnancy or Related Issues |  | Eating Disorders |
|  | Illness of Self |  | Relationships |  | Phobias |
|  | Illness of Others |  | Self Esteem |  | OCD |
|  | Anger |  | Sleep Problems |  | Other (please specify)Bed Wetter |
|  | School Issues/ Refusal |  | Autistic Spectrum Disorder  |

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| --- | --- | --- | --- |
| **Referrer’s Name** |  | **Position** |  |
| Agency  |  |
| Address |  |
| Contact Tel No |  | Email |  |
| Signed |  | Date |  |

***Please email completed referrals to hello@yess.uk***

Office Use Only:

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| --- | --- | --- | --- |
| Date Received  |  | Date Considered  |  |
| Outcome | () Accepted ( )Closed ( )Signposted  | RationaleStaff Sign |  |

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| Detail any safeguarding concerns and actions taken |
|  |
| Staff Sign |  | Date |  |

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| Funding Path |
| AFA |  | YP |  | SLA  |  | CIN |  |
| Private Funded |  | GP  |  | Spot Provision |  | IFS |  |

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| --- | --- | --- | --- |
| Date IA  |  | Date Allocated  |  |
| Date Closed  |  | Reason for Closure  |  |

Closure:

|  |  |
| --- | --- |
| Intervention (IAG/1:1/Group) |  |
| Modality |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| EOTR  |  | ROMS Start |  | ROMS End |  | Sessions Offered |  |
| Sessions Delivered |  | Signposting (list agencies) |  |