**CHILDREN and YOUNG PEOPLE’S PROGRAMME REFERRAL FORM**

We offer programmes for children and young people aged 6­+ who have previously witnessed or experienced domestic abuse in the family or in their own relationships.

If the abuse is current then please ensure that appropriate referral to Children’s Services has been made.

The programmes are run according to demand and are also subject to availability, staffing and resources.

For more info please call the Wish Centre on 01254 260465.

**Before completing the referral please ensure the following:**

|  |  |
| --- | --- |
| **The parent/ carer is fully supportive of the referral? (Please contact us if there are any exceptional circumstances)** | YES |
| **The parent/carer/referrer is willing and able to arrange transport to and from the programmes where relevant? (unfortunately WISH cannot provide transport)** | YES |
| **The service has been discussed with the young person and are they willing to engage?** | YES |
| **The young person has been a victim of domestic abuse**  **(Please indicate which option applies)** | Within family    Within own relationship |

|  |  |
| --- | --- |
| In some circumstances we may be able to offer programmes remotely for young people age 11+ (Eg via Zoom) Please indicate if this is something that the young person would be willing and able to do. | Yes / No  (please delete as appropriate) |

**Referrer’s details**

|  |  |
| --- | --- |
| Name |  |
| Job role / relationship to lead referral |  |
| Agency / organisation |  |
| Address |  |
| Contact number |  |
| Email address |  |

**Child / young person’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Child / young person’s name |  | AGE  and  DOB |  |
| Address |  | Gender |  |
| Consent from young person? |  | Tel. no |  |

**Parent / carer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent / carer’s name |  | Legal status (parent, carer, etc.)? |  |
| Address |  | Consent obtained? (if child is under 16) |  |
| Tel. Number |  | Email address |  |

**Perpetrator Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Perpetrator details |  | Legal status (parent, carer, etc.)? |  |
| Address |  | Any other relevant information (Contact etc ?) |  |
| D.O.B |  | Risk level |  |

**Is there anyone who is NOT permitted to have contact with the child(ren), i.e. collecting them from the programmes, etc.? If so please provide details.**

|  |
| --- |
|  |

**Ethnicity**

|  |  |  |  |
| --- | --- | --- | --- |
| White British |  | British Asian |  |
| Asian - Indian |  | Asian – Pakistani |  |
| British Caribbean |  | Black Caribbean |  |
| Dual heritage, please specify: |  | Other, please specify: |  |
|  |  |  |  |

**Sexuality**

|  |  |  |  |
| --- | --- | --- | --- |
| Heterosexual |  | Gay |  |
| Lesbian |  | Bisexual |  |
| Other |  | Prefer not to say |  |

**School / college**

|  |  |
| --- | --- |
| Name of school / college |  |
| Contact name & details |  |

**GP**

|  |  |
| --- | --- |
| GP name |  |
| Surgery |  |
| Tel no |  |

**Continuum of need**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CAF |  | Lead Professional |  | Tel. |  |
| Child in Need |  | Social Worker |  | Tel. |  |
| Child Protection |  | Social Worker |  | Tel. |  |

**Has the case been heard at MARAC?** If yes, when? .............................................................

**Disabilities / any additional support needs identified / any current medications**

|  |
| --- |
|  |

**Details of any siblings and any relevant family history**

|  |
| --- |
|  |

**Support Structure – any other professionals involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Role | Agency | Tel |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Reason for referral – please provide as much detail as possible**

|  |
| --- |
|  |

**Concerns about behaviour / coping strategies**

|  |
| --- |
|  |

**Any risk to self / others**

|  |
| --- |
|  |

**Relationships / social relationships**

|  |
| --- |
|  |

**Please specify any allergies or dietary requirements:**

|  |
| --- |
|  |

**Young Person’s Voice –** (where possible in the YP’s words- What does the YP want to achieve from the referral? How does the YP feel about the referral? Is there anything else that the YP wants to tell us?)

|  |
| --- |
|  |

**Signed (referrer) ……………………………………………………….……. Date………………………**

**Signed (parent / carer) …………………………..……………………….. Date………………………**

**Signed (child / young person) ………………………………………….. Date………………………**

Please return the completed form to:

* Email: info@thewishcentre.org
* Post: Unit 21, Business Development Centre, Eanam Wharf, BB1 5BL
* Fax: 01254 269598