**RYPP REFERRAL FORM**

RYPP is a programme for young people and their parent/carer.

* The young person will be required to complete 9 sessions with their RYPP worker.
* The parent/carer will be required to complete 7 sessions with their Family Support RYPP worker.
* AND there will be 2 sessions at which the young person, parent/carer and RYPP workers will be present.

Sessions may be offered on a 1:1 or group basis.

The programmes is subject to client suitability and staff availability.

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 and willing to engage? | YES |
| The service has been discussed with the young person and are they willing to engage? | YES |

|  |  |
| --- | --- |
| In some circumstances we may be able to offer programmes remotely (Eg via Zoom) Please indicate if this is something that the young person and parent/carer would be willing and able to do. | Yes / No |

**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 |  |
| Email address |  | Tel. no |  |

**Parent / carer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent / carer’s name |  | Legal status (parent, carer, etc.)? |  |
| Address |  | Consent obtained? |  |
| Email address |  | Tel. no |  |

**Continuum of need**

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

**Support Structure – any other professionals involved**

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

**GP**

|  |  |
| --- | --- |
| GP name |  |
| Surgery and tel |  |

**Does the young person have any children? If so please provide details.**

|  |
| --- |
|  |

**Details of family structure and relationships (eg siblings, other parent/carers, young person’s relationships)**

|  |
| --- |
|  |

**Reason for referral**

|  |
| --- |
|  |

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

|  |
| --- |
|  |

**YOUNG PERSON**

**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 |  |

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

|  |
| --- |
|  |

**Coping strategies identified / observed** (e.g. alcohol, drugs, eating disorders, self-harm etc.)

|  |
| --- |
|  |

**Concerns about behaviour** (e.g. sleep pattern, bed wetting, appetite, withdrawal, aggression, etc.)

|  |
| --- |
|  |

**Any risk to self / others**

|  |
| --- |
|  |

**PARENT/CARER**

**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 |  |

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

|  |
| --- |
|  |

**Any other relevant info (eg. Risks, concerns, coping strategies)**

|  |
| --- |
|  |

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

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

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

Please return the completed form to:

* Email: info@thewishcentre.org
* Post: The Wish Centre, 43 King St, Blackburn, BB2 2DH
* Fax: 01254 269598

**Office Use Only**

**Received on: / / Added to database: / /**

**Reference Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**