**Children and Young People’s Early Intervention and Prevention**

**REFERRAL FORM**

Please check services and criteria before filling out the referral. If you are looking to refer to our services, please complete the referral form below with as much information as you can provide and send it to CYPservice@solacewomensaid.org. Following this, a member of our team will contact you to confirm the referral and information provided and pass this on to the relevant service. Our services are supporting young people who have survived violence and abuse.

**Please NOTE:** We will not be able to accept referrals that are not sufficiently completed or that are not within the service criteria outlined below.

**Please NOTE:** While we aim to allocate cases in a timely manner to appropriate support as soon as possible, this is not an emergency service.

**Through this form you can refer to:**

|  |
| --- |
| * **General Advocacy**

Boroughs: North LondonAge: 11-21 (24 if disability)Background: AnyGender: Any |
| * **CouRAGEus Counselling:**

Boroughs: Camden, Enfield, Greenwich, Haringey, Islington, Lambeth, Lewisham, Southwark. Age: 14-24Background: Black and MinoritisedGender: Female |
| * **CouRAGEus Multi Disadvantage Advocacy (MDA):**

Boroughs: Camden, Enfield, Greenwich, Haringey, Islington, Lambeth, Lewisham, Southwark. Age: 14-24Background: Black and MinoritisedGender: Female |
| * **General Counselling:**

Boroughs: Referrals Pan-London, sessions online or in Camden Office. Age: 8-21 (24 if disability)Background: AnyGender: Any**PLEASE NOTE:** a) SERVICE USERS MUST BE WILLING TO DO COUNSELLING ONLINE OR TRAVEL TO CAMDEN OFFICE. ONLINE COUNSELLING IS DISCOURAGED FOR SERVICE USERS UNDER 14 AND WILL BE EVALUATED ON A CASE-BY-CASE BASIS. SPEAK TO OUR DUTY LINE FOR FURTHER INFO. b) PLEASE HAVE REFERREES COMPLETE THE **SECTION 7 ON PAGE 6.**  |

Please return this to cypservice@solacewomensaid.org

To Tick Boxes, please click on the chosen box and select ‘ticked’ in the pop-up options.

1. **REFERRAL AGENCY DETAILS:**

|  |  |
| --- | --- |
| **Name and Job Title:** | **Organisation:**  |
| **Address:**  | **Telephone:** **Email:**  |
| **Date of the referral:**  |  |
| **Is the Young Person aware of this referral and consented to it?**(Please Note: We are unable to accept referrals made without the young person’s consent) | **[ ]  Yes [ ] No** |
| **Which service would you like to refer young person to?** **PLEASE CHECK PAGE 1 CRITERIA** | **[ ]  General Advocacy** **[ ]  CouRAGEus Multi-disadvantage Advocacy****[ ]  CouRAGEus Therapeutic support (Complete Page 6)****[ ]  General Counselling (Complete Page 6)** |

|  |  |
| --- | --- |
| **Young person’s Name and Surname:****(and Oasis number if applicable:)** |  |
| **Young Person’s Date of Birth and age:** |  |
| **Borough:** |  |
| **Fits CouRageUs criteria?** (Check page 1) | **[ ]  Yes [ ] No** |
| **Young Person’s Contact number:**(This should be the number that workers can use to reach the young person, please specify if parent’s/guardian’s) |  |
| **Safe to Contact?** |  |
| **Assumed Risk Level:**(Please note this is not a crisis or emergency service) | **[ ]  Standard [ ]  Medium [ ] High** |
| **Please briefly justify risk level:**(If high please specify current provision) |  |

1. **YOUNG PERSON’S DETAILS**

|  |  |
| --- | --- |
| **Email:** |  |
| **Home Address (if Applicable):** |  |
| **Who does the young person live with?** |  |
| **School/College and Address (if Applicable):** |  |
| **Next of kin (parental responsibility) and relationship to Young Person:**  |  |
| **N.o.K. Contact details:****Safe to contact?** |  |
|  |  |
| **Are Child Services Involved?**  | **[ ]  Yes [ ] No [ ] Don’t know****If yes:****[ ]  Child in need [ ]  Supervision Order****[ ]  Child protection [ ]  Voluntary Care Order** **[ ]  Care Order [ ]  Team Around the child** **[ ]  Other, specify:** |
| **Any other services involved (YOT, CAMHS)? If Yes, specify.** | **[ ]  Yes [ ] No [ ] Don’t know** |
|  |  |
| **Alleged Perpetrator Relationship to young person (if applicable):** |  |
| **Young Person’s care status:** |  |
| **Contact with perpetrator:** |  |
| **Conflict over contact:** |  |

1. **EQUALITIES MONITORING:**

|  |  |
| --- | --- |
| **Gender:** |  |
| **Transgender?**  |  |
| **Ethnicity:**  |  |
| **Relationship status:** |  |
| **Religion:** |  |
| **Sexual Orientation:** |  |
| **Disability (illness, impairment, allergies)** | **[ ]  Yes [ ] No****[ ] Physical disability [ ] Hearing disability** **[ ] Learning disability [ ] Vision disability** **[ ] Mental Health disability [ ]  Other:****Additional notes:**  |

1. **ACCESSIBILITY:**

|  |  |
| --- | --- |
| **Young Person’s primary language:** |  |
| **Is interpreter needed?** |  **[ ]  Yes [ ] No** |
| **Other accessibility requirements?** |  |

1. **REASONS FOR REFERRAL:**

|  |  |
| --- | --- |
| **Status of Abuse:** | **[ ]  Current [ ] Historic [ ] N/A [ ] Unknown** |
| **Types of Abuse Experienced:**(Tick all that apply) | **[ ]  Domestic Violence [ ]  Gang related violence** **[ ]  Sexual abuse [ ]  Rape** **[ ]  Forced marriage [ ]  Harassment and Stalking** **[ ]  Honour based violence [ ]  FGM** **[ ]  Trafficking [ ] Child Sexual Exploitation** **[ ]  Prostitution [ ]  Grooming/Exploitation****[ ]  Other:** |
| **Strains of Abuse Experienced:** (Tick all that apply) | **[ ]  Physical [ ]  Sexual [ ]  Financial [ ] Emotional** **[ ]  Coercive Control/Jealous behaviour. [ ]  Other:**  |
| **Has the CYP directly witnessed abuse of someone else? Yes [ ]  No [ ]** **Has the CYP indirectly witnessed abuse of someone else? Yes [ ]  No [ ]**  |
|  |
| **Please briefly outline reasons for referral and details of the case below, including any other relevant information:** |
|  |

1. **ISSUES AND SUPPORT NEEDS**

|  |  |
| --- | --- |
| **Current Issues:**  |  **[ ]  Challenging behaviour**  **[ ]  Struggling to express emotions**  **[ ]  Suicidality** **[ ]  Struggling to express anger constructively**  **[ ]  Is withdrawn or continually unhappy** **[ ]  Struggling with school attendance** **[ ]  Lack of aspiration and motivation**  **[ ]  Lack of interest into after school activities**  **[ ]  Lack of friends (social isolation)**  **[ ]  Low self-esteem and confidence** **[ ]  Using substances**  **[ ]  Self-harming/ at risk of self-harming**  **[ ]  Struggling with bullying/cyber bullying**  **[ ]  At risk of offending** **[ ]  Involvement with crime**  **[ ]  Risk of gang association** **[ ]  Other:**  |
| **Is the young person in conflict with any other person?**  |  **[ ]  Yes [ ] No [ ] Don’t know** |
| **Level/nature of conflict**  |  |
| **Anything else that would impact young person’s engagement with the service/programmes?**(If Yes, please specify) | **[ ]  Yes [ ] No [ ] Don’t know** |

1. **COUNSELLING REFERRALS ONLY: PLEASE COMPLETE**

**This section is to be completed by the CYP being referred to the counselling services, if needed, with the support of the referrer.**

**These questions are to assess your state of mind, your needs and wants, and whether counselling is a good fit for you at this time.**

**CYP TO COMPLETE:**

|  |  |
| --- | --- |
| **What are your hopes going into counselling?** **(Just 3-4 bullet points)** | *
*
*
 |
| **How would you like counselling to support you?****(Just 3-4 bullet points)** | *
*
*
 |
| **Do you feel ready to start counselling?** |  |

**Please confirm you understand:**

|  |  |
| --- | --- |
| Counselling sessions will take place online or in our offices in Camden. | **[ ]  I understand** |
| Online counselling is discouraged for CYP under 14 years of age.  | **[ ]  I understand** |

For any questions or information please contact our duty line at cypservice@solacewomensaid.org