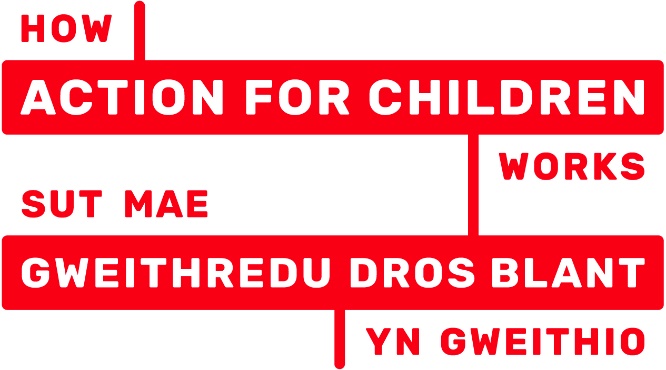
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**Referral Form:** V.2.1 (Feb 2019)

**Women and Girls Together Service**

**Young Person’s Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Young Person:** |  | |  |  | **D.o.B** |  |
| **Address** |  | | | | **Postcode:** |  |
| **Young Person’s Mobile No.** |  | | | | **Ethnicity:** |  |
| **Name of School/College or other Education Provision:** |  | | | | | |
| **Is the Young Person a Young Carer?** | **Yes 🗆**  **No 🗆**  **Not Known 🗆** | **Is the Young Person Looked After or a Care Leaver?** | | | | **Yes 🗆**  **No 🗆**  **Not Known 🗆** |
| **Does the Young Person have a disability or any additional learning needs ?** | **Yes 🗆**  **No 🗆**  **Not Known 🗆** | **If yes, please specify** | | | |  |

**Parent/Carer’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Parent/Carer** |  | **Relationship to Young Person** |  |
| **Mobile:** |  | **Home Tel No.** |  |
| **Address** *(If different from young person)* |  | | |

**Referrer Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  | **Role/Title:** | |  |
| **Agency:** |  | | | |
| **Address:** |  | | | |
| **Tel No:** |  | **Email:** |  | |
| **Signed:** |  | **Date:** |  | |

Please indicate if the young person is currently subject to any of the following plans:-

**Child Protection Plan 🗆 Care and Support Plan 🗆 Risky Behaviour Plan 🗆**

**SERAF🗆 SERAF score: Adult Safeguarding 🗆**

***\*\* Please note that if the young person is subject to a SERAF, and referral to this service is part of the SERAF plan, please forward a copy of the SERAF Risk Assessment and current plan along with this referral.***

**Please detail any agencies known to be currently involved in supporting the young person,** such as Social Care, Team Around the Family, CAMHS, Youth Worker Support, Youth Offending Team, School Counsellor, School Nurse, Emotional Wellbeing Service, Gwalia, Hafan Cymru, Choices.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Agency** | **Professional / Practitioner Name** | **Contact details** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |

|  |
| --- |
| **Risks and Concerns:**  Please tick all that apply to the female that you are referring, and provide further details in the ***Reasons for Referral*** section below: |
| Low Confidence/Self Esteem Mental health concerns 🗆 Self harming behaviour 🗆  Suicidal ideation 🗆 Suicide attempt(s) 🗆 Recent Bereavement/loss 🗆  Domestic Violence (Parents/Carers) 🗆 Parent/family member experiences sexual violence 🗆  Parental Mental Health Concerns 🗆 Parental Substance Misuse 🗆 Parent criminality issues🗆  Unhealthy/Abusive Relationship (Young Person) 🗆 Victim of Sexual Violence 🗆  Stalking 🗆 Repeated STIs/pregnancies/terminations 🗆 Concerns of substance misuse 🗆  Risk of or have been sexually exploited 🗆 Experiences/concerns of grooming 🗆  Concerns/issues with online safety 🗆  Involved or associated with gang/youth violence 🗆 Criminality (Young Person) 🗆  Poor school attendance 🗆 NEET (Not in Education/Employment or Training) 🗆  Victim of bullying 🗆  Historic social care involvement 🗆 Current social care involvement 🗆  Experienced/concerns of neglect 🗆 Experienced/concerns of emotional abuse 🗆  Experienced/concerns of physical abuse 🗆 Homeless 🗆 |

|  |
| --- |
| **Reasons for Referral:**  Please outline the reasons for your referral and provide further details around the above presenting risks and concerns that you have identified for the young person. |
|  |

**Consent**

*It is important that this referral has been discussed with the Young Person and that they have an understanding of the support being offered and a willingness to engage.*

***Please tick this box to indicate that the young person is aware of this referral****. 🗆*

**Parents/Guardian Consent**

|  |
| --- |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent to a referral being made to Action for Children for the  Women & Girls Together Project for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child/young person).  I understand that the information on this form will be stored on an electronic database, compliant with the DPA (Data Protection Act) and used for the purpose of providing services to this child/young person.  I agree to the information recorded on this form being shared with other projects & organisations who may also be able to provide services.  **Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Young Person Consent ( If Aged 16yrs and over)**

I give my consent to a referral being made to the Women and Girls Together Service.

I understand that the information on this form will be stored on an electronic database, compliant with the DPA (Data Protection Act) and used for the purpose of providing services to this child/young person.

I agree to the information recorded on this form being shared with other projects & organisations who may also be able to provide services/support to me.

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What happens next?**

|  |
| --- |
| Send this referral to:  Women and Girls Together Service, Action for Children, Penfynnon, Hawthorn Rise, Haverfordwest SA61 2AX  *Email referral to* [*womenandgirls@actionforchildren.org.uk*](mailto:womenandgirls@actionforchildren.org.uk)  Telephone enquiries to Lisa or Donna-Marie 01437 761330  One of the team will contact you to confirm receipt of your referral and request any additional information that may be needed. We will discuss next steps for contacting the family/young person and arranging an initial visit. |