|  |
| --- |
| **Referrer Details** |
| Referrer nameand Organisation |  | Role |  |
| Telephone number |  |
| Address |  |
| e-mail address |  |
| **Consent to referral? -** **YES/NO**Who by? (Young person/parent/carer) -  |  | Does the young person, Parent/ Carer consent for information to be shared with partner agencies?( Young Peoples’s Youth Justice and Engagement)**YES/ NO** | Date -  |
| Can the project contact the young person directly?**YES/NO** |  |
| What outcomes would referrer like to see? |  |

**Referral Form**

|  |
| --- |
| **Area of Engagement (Please Tick all that apply)** |
| Youth Session |  | Co-production Network  |  | Detached Youth Work |  | Holiday Activities |  |
| Back On Track |  | School Based Activities |  | Other  |  |  |  |

|  |
| --- |
| **Young person’s Information** |
| First Name |  | Surname |  |
| Date of Birth |  | Age |  |
| Contact name (eg, parent/carer) |  |
| Contact Number |  | Email |  |
| **Gender** (please tick) |
| Female |  | Male |  | Other |  | Prefer not to say |  |
| Address |  | Post Code |  |

|  |
| --- |
| **Are there any risk factors that the project may need to be aware of in order to support the young person?****YES/NO** |
| Please detail –  |

|  |
| --- |
| **Disability** (please tick and inform of any medication) |
| None |  | Learning Disability |  | Mental Health Condition |  | Physical Impairment |  |
| Visual impairment |  | Hearing Impairment |  | Autism  |  | Other (provide details below) |  |
| Does the young person have any other support requirements?Please detail –  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Does the young person have caring responsibilities?**(please tick) | Yes |  | No |  | Details |  |
| **Does the young person receive support from an organisation with this?** (please tick) | Yes |  | No  |  | Details  |  |
| *Caring - helps look after a relative who has a condition, such as a disability, illness, mental health condition, or a drug or alcohol problem. For example parents or care for a brother or sister***.** |
| Does the young person receive any support from any other organisations?**Please specify** -  |  |

This section is to be completed by YIF team:

|  |  |
| --- | --- |
| **Date received:** |  |
| **Initial contact date:** |  |
| **Actions:** |
| **Name:** |

**Please return this completed form to** jmcstravick@teesvalleyymca.org.uk

**Contact June McStravick on 01325 462452 ext 1006**