|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | |
| Referrer name  and 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**