 **REFERRAL FORM**

**\*ALL OF THIS SECTION MUST BE COMPLETED IN FULL FOR US TO ACCEPT THE REFERRAL\***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** | **Last Name:** | | | **Age:** | **Date of Birth:**  **/ /** | **Gender** (please tick):  **Male Female** | | **Nebula Number** (office use only): |
| **Address:** House number/Name/Street/Area/Town  **Postcode: Consent to use this info to contact client? Y N** | | | | Living with Parents/Relatives Living independently/Unsettled Accom Child Looked After  Living independently/Settled Accom Living independently/NFA YP Living in Secure Care  YP Living in Care Living in Supported Housing | | | | |
| **Home telephone:** | | Consent to use? **Y N** | | **Young Person’s Ethnicity:** | | | | |
| **Young person’s mobile telephone:** | | Consent to use? **Y N** | | **Notes** (Please use additional sheet if needed): | | | **Young Person’s Current Status::**  **Please tick YES √ of NO X or ‘NOT LNOWN’ - leave blank**  MH treatment need identified Have a CAF/EHA  In contact with YOT/YOS Currently Homeless  Involved in Sexual Exploitation Young Carer  Involved Self Harm Currently Pregnant  Involved in unsafe drug use Looked after by LA  Involved in Offending Engaged in unsafe  In contact with Disability Services sex  With Drug/Alcohol using parents/carers | |
| **Other Mobile Telephone** | | Consent to use? **Y N** | |
| **Email Address:** | | Consent to use? **Y N** | |
| **Main Substance: (\*MUST be completed)** | | | |
| **Substance 2:** | | | |
| **Substance 3:** | | | |
| **Does Parent/Guardian of YP know of this referral?** **YES** **NO** | | | |
| **Referral Source: Please ensure ONE of these is ticked**  CLA – Child Looked After GP Adult Treatment Provider Youth Offending Institute Website  Children & Family Services A & E Young People’s Treatment Provider Secure Training Centre Employer  Universal Education Hospital Non Treatment Subs Misuse Service Secure Children’s Home  Alternative Education Non Child Mental Health Service FRANK Helpline Post Custody  Targeted Youth Support Primary Care Self-referral via health professional Self  Outreach Children’s Mental Health Service Crime Prevention Relative  YP Housing Provider School Nurse YOT/YOS Concerned Others | | | | | | | **Young person’s Education Status:**  **Please tick YES √ of NO X or ‘NOT KNOWN’ - leave blank**  Mainstream Education Regular Employment  Alternative Education  Unemployed and not seeking  work  Temporarily Excluded  Economically Inactive Caring Role  Permanently Excluded  Economically Inactive Health Issue  Persistent Absentee  Apprenticeship/Training Voluntary Work | |
| **Referrer Contact Details:** NAME/ADDRESS/E-MAIL | | | **Violence Risk/Risk to EB Worker or Others:**  (Low/Medium/High)  (Risk to Peers/Family Workers etc) | | | **Is a SOCIAL WORKER involved?** YES NO | | |
| **If not involved, has a CAF been completed?** YES NO | | |
| **Signature of Referrer:** | | | **Date Referral sent to Early Break:**  **/ /** | | | **Name/information of Social Worker/Lead Professional:** | | |

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