 **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 AfterLiving independently/Settled Accom Living independently/NFA YP Living in Secure CareYP 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/EHAIn contact with YOT/YOS Currently HomelessInvolved in Sexual Exploitation Young CarerInvolved Self Harm Currently PregnantInvolved in unsafe drug use Looked after by LAInvolved in Offending Engaged in unsafeIn contact with Disability Services sexWith 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 WebsiteChildren & Family Services A & E Young People’s Treatment Provider Secure Training Centre EmployerUniversal Education Hospital Non Treatment Subs Misuse Service Secure Children’s HomeAlternative Education Non Child Mental Health Service FRANK Helpline Post CustodyTargeted Youth Support Primary Care Self-referral via health professional SelfOutreach Children’s Mental Health Service Crime Prevention RelativeYP 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 EmploymentAlternative Education Unemployed and not seeking workTemporarily Excluded Economically Inactive Caring RolePermanently ExcludedEconomically Inactive Health IssuePersistent AbsenteeApprenticeship/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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