Referral Form for YP therapy

Information if referring to SV2

Criteria:

SV2 can work with young people aged 14-17 and they will be offered 10 sessions of therapy.

Consent for the referral to us must have been received from the young person or from the parent/carer.

Child must be safe from and harm and not be in contact with perpetrator

Client must be living in Derbyshire/Derby City.

Once completed please send to: SV2 41 Leopold Street, Derby, DE1 2HF

SV2 will send a letter to the client to confirm the referral has been received.

**1. Referral Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Referral: |  | Date of Disclosure: |  |
| Details of Referrer: | Name: |  |
| Role: |  |
| Email Address: |  |
| Contact Number: |  |

**2.** **Details Child/Young Person to be referred**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth: |  |
| Address: |  |
| OK to write? Yes / No  |
| Gender: | Male Female Trans/non-binary |
| Ethnicity: |  |
| Language spoken at home: |  |
| Any disability: |  |
| Legal Status: |  |
| Religion: |  |
| Address: |  |
| Mobile Number  |  |
| OK to text: Yes / No OK to leave voicemail: Yes / No  |
| Home Number  |  |
| OK to leave voicemail: Yes / No  |
| Number and age of Siblings: |  |

**3. Police Investigation / legal proceedings**

|  |  |
| --- | --- |
| Details of any pending legal proceedings: |  |
| Crime Reference Number: |  |
| Key Contact /OIC |  |

|  |  |
| --- | --- |
| Video Recorded Interview completed: Yes/No | Date of Video Recorded Interview: |

|  |  |
| --- | --- |
| Forensic medical completed? If yes, date.  |  |

**4.** **Details of GP and Education**

|  |  |  |
| --- | --- | --- |
| GP and GP practice:  |  | Tel: |
| Education: School/College: Key Contact: |  | Tel: |
|  |

**5.** **Details of Child/Young Person’s Parent/Carer/Key Person**

|  |  |
| --- | --- |
| Name: |  |
| Relationship to Child/Young Person: |  |
| Parental responsibility:  | Yes/No |
| Address: |  |
| OK to write: Yes / No  |
| Contact Number: |  |
| OK to text: Yes / No OK to leave voicemail: Yes / No |

**6.** **Consent**

|  |  |
| --- | --- |
| Parent/ Carer/Key Person Consented to Referral:  | Yes/No |
| Child/Young Person Consented to Referral:  | Yes/No |

**7**. **Case Details**

|  |  |
| --- | --- |
| Date & location of Offence: |  |
| Summary of Abuse: |  |
| Age at time of abuse |  |
| Nature of Abuse: | Contact Penetrative Sexual:  | Yes/No |
| Contact Maybe Penetrative Sexual | Yes/No |
| Contact Non-Penetrative Sexual | Yes/No |
| Non-Contact Sexual | Yes/No |
| Physical | Yes/No |
| Unknown | Yes/No |
| Perpetrator Details: |  |  |
| Relationship of Perpetrator to the Child/Young Person: |  |  |
| Key Case Notes/Comments:(work already completed, any assessments completed,  |  |  |

**8**. **Safeguarding**

|  |  |
| --- | --- |
| Safeguarding concerns and risks identified: (please attach any relevant documentation) |  |
| Has a safeguarding referral been made:  | Yes/No |
| Social Worker’s Contact Details:  |  |
| Any known risk to staff: |  |

**9.** **Details of Other Organisations, Agencies and Professionals Involved e.g. Paediatrician; CHISVA; CAMHS**

|  |  |
| --- | --- |
| Organisation/Agency/Service: |  |
| Key Person: |  |
| Key Person’s Contact Details: |  |
| Nature of Involvement: |  |

|  |  |
| --- | --- |
| Organisation/Agency/Service: |  |
| Key Person: |  |
| Key Person’s Contact Details: |  |
| Nature of Involvement: |  |

|  |  |
| --- | --- |
| Organisation/Agency/Service: |  |
| Key Person: |  |
| Key Person’s Contact Details: |  |
| Nature of Involvement: |  |

10. **Any Other Useful Information**:

|  |  |
| --- | --- |
| Any other useful information not covered in the above sections:  |  |

 I Consent to SV2 Contacting the agencies mentioned above