REFERRAL OF A YOUNG PERSON FORM

Name of Young Person:		Gender:	

Name and Address of Referring Authority: (please include postcode)

Name of Social Worker responsible:			
Contact Number:		Out of Hours; EDT number:	

Additional Material Attached: (if so please give details)

Signed:		Date:	
Name:		Status:	

SECTION A: DETAILS OF A YOUNG PERSON'S FAMILY	
Surname:	
Forename (s):	
Also known as:	
Date of Birth	
Current Address:	
Name of householder or person responsible:	
Telephone number:	
Usual Home Address:	
Name of householder or person responsible	
Telephone number:	

Person(s) who have significant relationships with young person:

Name	Current Age	Nature of Relationship	Address & Tel. No:

Name of Young Person:	

SECTION B: PLACING AUTHORITY	
Telephone number of SSD:	
Fax number:	
Name of Senior Social Worker:	

SECTION C: EDUCATION

Name and Address of Local Education Authority	
Name of contact person: (with knowledge of case)	
Contact Tel. no:	

Schools or other education establishments attended (most recent first):

Dates from/to	Name and address of school	Contact person	Tel no:

Name of Young Person:	

Please outline the current state of the young person(s) educational achievements, aims, and needs:				
Is the young person statemented?				
Yes:		No:		Date:
Has he/she ever been expelled, suspended or otherwise required to leave an education establishment other than because of age?				
If yes, please give details with dates:				
Dates:		Details:		

Name of Young Person:	

SECTION D: LEGAL AND BEHAVIOURAL FACTORS				
Who has parental authority?				
Is the young person on the child protection register?	Yes		No	

Please give details of any relevant court orders:

Date made	Date expired	Court	Case Ref	Details

Please give any other details of anyone the young person should not be in contact with: (give reasons)

Give details of any past abuse or any other victimisation of the young person:

Date(s) of occurrence	Nature of abuse	Name, age & gender of abuser (include other young people)	Relationship to young person

Name of Young Person:	

Give details of any known or suspected past offences by the young person, including may matters currently in process of investigation or trial:

Date(s)	Details of Offence	Suspected only or court case, ref and date:

Give details of any other known or suspected behaviour by the young person which might be a cause of danger to the young person, other people or property: (Include details of any known or suspected substance abuse/addiction)

Date(s)	Details:

Name of Young Person:	

SECTION E: HEALTH & MEDICAL FACTORS

Young person's current or most recent practitioners:

G P Name:	**Dentist Name:**	**Optician Name:**
Address:	**Address:**	**Address:**
Tel:	**Tel:**	**Tel:**

State whether the young person is known to have had any of the following: (please tick)

☐	**Asthma**	☐	**Diphtheria**	☐	**Measles**	☐	**TB**
☐	**Bronchitis**	☐	**Whooping Cough**	☐	**Meningitis**	☐	**Polio**
☐	**Chicken Pox**	☐	**German Measles**	☐	**Tetanus**	☐	**Mumps**
☐	**Diabetes**	☐	**Heart Disease**	☐	**Scarlet Fever**	☐	**Eczema**

Does the young person smoke: ☐ **OR Drink alcoholic drinks:** ☐

Immunised against: (please tick)

☐	**Diphtheria**	☐	**Measles**	☐	**Small Pox**	☐	**Polio**
☐	**German Measles**	☐	**Whooping Cough**	☐	**Tetanus**		

Has the young person had a BCG: ☐ **Skin Test?** ☐ **Injection?**

Is the young person believed to have any of the following? If so please give details below:

☐	**Allegories**	☐	**Phobias**	☐	**Incontinence**
☐	**Menstrual Pain**	☐	**Special Dietary Needs**	☐	**Congenital Condition**
☐	**Sight/Hearing Impairment**	☐	**Other Gynaecological Complaint**		

Details of any thing ticked in above section: (or continue on separate sheet)

Is it possible/likely/known that the young person is a high risk with respect of the following: (Please tick)

HIV	☐	**Possible**	☐	**Likely**	☐	**Known**	
Hepatitis	☐	**Possible**	☐	**Likely**	☐	**Known**	

INITIAL QUESTIONS

Disclosure information from Social Services failure to answer any questions will result in the placement being automatically refused until full information is received in writing.

Name of Young Person:	

Does the local Authority require the following services?

PLEASE TICK BOX THAT APPLIES:

NO	YES	
☐	☐	**Short Term assessment placement**
☐	☐	**Assessment for preparation of court reports**
☐	☐	**Psychological assessment through the agencies own consultants**
☐	☐	**Psychiatric treatment**
☐	☐	**Education provided by What's Out There Limited?**
☐	☐	**Special ethnic and/or religious cultural development/education (please give details)**
☐	☐	**Teaching for English as a second language**
☐	☐	**Independence/Outreach service for support of children/young person after discharge**
☐	☐	**Preparation for fostering**
☐	☐	**Preparation for adoption**
☐	☐	**Physiotherapy**
☐	☐	**Occupational Therapy**
☐	☐	**Speech Therapy**
☐	☐	**Social Training for children/young people with learning difficulties**
☐	☐	**Other specialist service (if so please state below:**

Name of Young Person:	

Does the young person you wish to place with What's Out There Limited have any of the following characteristics?

PLEASE TICK ONE BOX

No	Yes	
☐	☐	**Require special diet for reasons of health, religion or culture**
☐	☐	**Pregnant**
☐	☐	**Have a baby**
☐	☐	**Speaks little or no English**
☐	☐	**Epileptic-Grand Mal**
☐	☐	**Diabetic**
☐	☐	**Asthmatic**
☐	☐	**Speech Impaired**
☐	☐	**Moderate Learning Difficulties**
☐	☐	**Autistic Mild**
☐	☐	**Autistic Severe**

Does the young person you wish to place with What's Out There Limited have recent or current (within the past 12 months) history of any of the following experiences or behaviour?

No	Yes Recent	Yes Current	
☐	☐	☐	**Eating disorders (anorexia/bulimia)**
☐	☐	☐	**Enuresis or urine incontinence**
☐	☐	☐	**Encopresis or faeces incontinence**
☐	☐	☐	**Victim of sexual abuse by females**
☐	☐	☐	**Frequent or persistent glue/solvent abuse**
☐	☐	☐	**Frequent or soft drug abuse (please state drug if known)_____**
☐	☐	☐	**Absconding**
☐	☐	☐	**Exclusion from day school**
☐	☐	☐	**Excessive verbal abuse towards support workers/or other carers**
			Other (please specify below:)

Name of Young Person:	

MEDICAL
Please tick box for the primary disability and give additional information as needed:

☐ **Cerebral Palsy**

☐ **Epilepsy**

☐ **Hearing Impairment**

☐ **Speech and Language disabilities**

☐ **Autism**

☐ **Learning difficulties – moderate**

☐ **Learning difficulties – severe**

☐ **Other**

☐ **A.D.H.D**

☐ **A.D.D**

Previous	Recent	Current	
☐	☐	☐	**Victim of sexual abuse by female**
☐	☐	☐	**Victim of sexual abuse by male**
☐	☐	☐	**Victim of physical abuse by female**
☐	☐	☐	**Victim of physical abuse by male**
☐	☐	☐	**Trauma (including victims of war/torture)**
☐	☐	☐	**Suicidal threats or attempts**
☐	☐	☐	**Self-injury**
☐	☐	☐	**Bullying of others**
☐	☐	☐	**Fire setting**
☐	☐	☐	**Stealing from family/peer group**
☐	☐	☐	**Burglary/theft from member of public/business or other**
☐	☐	☐	**Physical violence towards male young person**

Name of Young Person:	

The information contained herein is received in good confidence and faith. Responsibility however will be placed upon Local Authority or other completing this form and / or supplying additional information for any errors, omissions or inaccuracies in the information or for any loss or damage which may result from reliance being placed upon it.

Please detail any additional information you feel relevant below:

Signed:		Date:	
Name:		Status:	