

For official use only:

Date Referral Received: ………….......

Referral agent notified by letter Yes/No

Appointment letter sent, date ……..........

Allocation Date…………………..

**Referral Form**

 

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| **Client assessed:**  **Client allocated:** | Name:  Date: | **School Yes No**  **Work Yes No**  **FE/Training Yes No**  **NEET Yes No**  **In Custody Yes No**  **Other? Specify** |
| Name:  Date: |
| Client Details:  Name  D.O.B./age  Address:  Postcode:  Telephone: | | ***(Information below should be provided by / about individual with Parental Consent)***  Parent/ Carer/Legal Guardian  Name:  Address:  Postcode:  Telephone: |
| GP Contact Information | | Name:  Address:  Tel: |
| Referrer’ Details  Name:  Address:  Postcode:  Telephone:  Profession:  E Mail: | | Are you the main contact? Yes/No  If no please give detail of the person who is to be the main contact.  Name:  Address:  Telephone:  Profession: |
| Reason for referral: | | |

|  |  |
| --- | --- |
| Please confirm that the client has agreed to this referral being made? | YES/NO |
| Have parents/guardian been informed of this referral? | YES/NO |
| Is this client currently engaged with another service? (If yes please give details :) |  |

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| --- | --- |
| Are you aware of any literacy difficulties? | If yes please give details: |

|  |  |
| --- | --- |
| Is English the young person first language? | Yes/No |
| If not specify preferred language |  |

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| --- | --- |
| Does this young person have a disability? | If yes please give details |

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| **Additional Information**  (Please provide as much relevant information in relation to the client to enable appropriate and adequate services to be identified) |

**\*Please be aware the client has the right to see this form\***

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| Any risk identified? (Suicide, self harm, aggression, substance misuse, other risk taking behaviours, history of violence?) | If yes please give details: |

|  |  |
| --- | --- |
| Client ID allocated on receipt of referral by Admin. | How did you hear about this service? |
| Signed: | Date |

***It is the referral agent’s responsibility to ensure that the client can access this service.***

**PLEASE RETURN TO:**

|  |  |
| --- | --- |
|  | |
| **Please return Western Trust referrals to:** | |
| **ASCERT**  **7A Dublin Road**  **Omagh**  **BT78 1ES**  **Tel: 0800 2545 123**  [**clare@ascert.biz**](mailto:clare@ascert.biz) |  |
|  | |
|  | |

**Service will record provide or receive information in accordance with the Data Protection Act (1998)**

**Receiving Information**

* **Personal information held is subject to legal duty of confidence and should not normally be disclosed without consent.**
* **All information received will be treated with respect and regard for confidentiality.**

**Consent**

* **If the client asks that their parents are not informed of the content of their work with us, this must be indicated on the referral form. We will comply with such requests except in circumstances where the staff member believes that information disclosed to them by the young person is of a child protection nature. Disclosure of this type of information will then be made to parents/carers after an attempt has been made by the staff member to have the clients consent to the disclosure and after consultation with a manager.**

**Giving Information**

* **Information about the client will only be given with consent, or when it is assessed that the client is suffering, or likely to suffer, from significant harm.**
* **Where information must be shared with relevant individuals/agencies, adheres to the Best Practices Guidelines**

**(Working together to Safeguard Children 2006)**