**Young People**

**Haringey Wellbeing Network Referral Form**

We ask all our service users to complete this form. You will only have to do this once, no matter how many of our services you would like to access. All information given will be kept confidentially and anonymously and will only be used to produce statistics about our services. You may tick ‘Prefer not to say’ if you do not wish to provide certain information.

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| **Referrer Information** | | | | | | | | | | | | | | | | |
| **Name of Referrer :**  **Position :** | | | **Office**  **Address :** | | | | | | | | | **Phone number :**  **Email Address :** | | | | |
| **YP & Parent Guardian/Carer Information** | | | | | | | | | | | | | | | | |
| **Name & Surname of YP:** |  | | | | | | | | | | | | | | | |
| **Age & Date of Birth:** | **Age:** | | | **DOB:** | | | | | | | | |  | | | |
| **YP Consent to participate** | **Yes** | | | **No** | | | | | | | | | | | | |
| **Is YP able to travel to appointments?** | **Yes** | | | **No** | | | | | | | | | | | | |
| **Gender** | **Male**  **Other** | | | | **Female**  **Prefer not to say** | | | **Intersex** | | | | | | **Non-binary** | | **Transgender** |
| **Mobile:** | | | **Tel:** | | | | | | | | | **Email:** | | | | |
| **Address:**  **Postcode:** |  | | | | | | | | | | | | | | | |
| **Do they argee to this referral ?**  **Yes**  **No** | **Who does the YP live with:**  **Relationship to YP :** | | | | | | | | | | | | | | **Accomadated by the local authority**  **Yes**  **No** | |
| **Name of Parent/Carer:** | **Mobile Number :**  **Address if different from above :** | | | | | | | | | | | | | | **Do they argee to this referral ?**  **Yes**  **No**  **N/A** | |  |
| **Has the YP ever been diagnosed with or sought treatment for any of the following mental health conditions?**  Tick all that apply. | Anxiety  Bipolar disorder  Depression  Obsessive compulsive disorder  Post-traumatic stress | | | | | | | | | | | | | | Psychosis  Schizophrenia  Prefer not to say  Other (please detail): | |
| **Referral Information** | **Reason for referral (presenting problems, duration, severity, including nature of mental health concerns)** | | | | | | | | | | | | | | | |
| **Background Information** | **Significant family difficulties, illness, parental separation. Changes at home/school.** | | | | | | | | | | | | | | | |
| **WHAT IS THE REFERRER HOPING TO ACHIEVE BY MAKING THIS REFERRAL?** |  | | | | | | | | | | | | | | | |
| **RELEVANT MEDICAL HISTORY/CURRENT MEDICATION** |  | | | | | | | | | | | | | | | |
| **Do you have any access needs that we should know about?** | Interpreter required  Mobility restricted (ground floor appointments only)  Reading/writing asssistance required  Other (please detail): | | | | | | | | | | | | | | | |
| **Do you consider yourself to have a disability?**  Tick all that apply. | A specific learning difficulty  such as dyslexia, dyspraxia or AD(H)D  General learning disability (such as Down’s syndrome)  A social/communication impairment such as Asperger’s syndrome/other autistic spectrum disorder  A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy  A physical impairment or mobility issues, such as difficulty using arms or using a wheelchair or crutches | | | | | | | | | Deaf or serious hearing impairment  Blind or a serious visual impairment uncorrected by glasses  A disability, impairment or medical condition that is not listed above  Other (please detail):  No known disability  Prefer not to say | | | | | | |
| **Employment status:** | Employed | | | | | Unemployed In training/education | | | | | | | | | | |
| **Does the YP have any spent or unspent criminal convictions?**  *(Please note that answering “yes” is not a disqualifying factor)* | Yes | | | | | No | | | | | Prefer not to say | | | | | |
| **Ethnic origin:** | **Asian**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (please detail)  **Black**  African  Caribbean  Any other black background (please detail)  **Mixed / multiple ethnic groups**  White & Black Caribbean  White & Black African  White & Asian  Any other (please detail) | | | | | | | | | | | | | | **White**  English / Welsh / Scottish / Northern Irish  Irish  Gypsy or Irish Traveller  Any other white background (please detail)  **Other Ethnic Group**  Arab  Any other ethnic group (please detail) | |
| **Religion or belief:** | Buddhist  Christian  Hindu  Jewish  Muslim | | | | | | | | Sikh  Other (please detail):  No religion  Prefer not to say | | | | | | | |
| **Sexual orientation** | | Asexual  Bisexual  Gay man  Gay woman / lesbian | | | | | Heterosexual  Other (please detail):  Prefer not to say | | | | | | | | | |
| **GP contact details:** | | Name:  Address: | | | | | | | | | | | | | Contact number:  Email: | |

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| **Are there other Professionals involved with the Young Person?** | | **Yes** |  | | **No** |  |
| **If “yes”, please tick the appropriate box and give the relevant details** | | | | | | |
| **Professional** | **Current contact – name** | | | **Past contact – name & year** | | |
| **Psychiatrist** |  | | |  | | |
| **Clinical Psychologist** |  | | |  | | |
| **Educational Psychologist** |  | | |  | | |
| **Family Therapist** |  | | |  | | |
| **Educational Welfare Officer - EWO** |  | | |  | | |
| **Community Psychiatric Nurse – CPN/CMHN** |  | | |  | | |
| **Residential Key Worker** |  | | |  | | |
| **Child & Adolescent Mental Health Service** |  | | |  | | |
| **Youth Offending Services** |  | | |  | | |
| **Other** |  | | |  | | |
| **Does the young person/ parent/carer have a disability? Please provide details.** |  | | | | | |

**Risk Assessment (To be completed by all Refers).**

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| Factors | History | If yes, please describe |
| **Violence to others** | **Yes No**  **❑ ❑** |  |
| **Cruelty to animals** | **Yes No**  **❑ ❑** |  |
| **Use/collection/carrying of weapons** | **Yes No**  **❑ ❑** |  |
| **Self Neglect** | **Yes No**  **❑ ❑** |  |
| **Deliberate self harm** | **Yes No**  **❑ ❑** |  |
| **Deliberate fire setting** | **Yes No**  **❑ ❑** |  |
| **Substance Use/Misuse** | **Yes No**  **❑ ❑** |  |
| **Poor supervision at home** | **Yes No**  **❑ ❑** |  |
| **Exploitation or abuse (physically/emotionally/**  **sexually)** | **Yes No**  **❑ ❑** |  |
| **Inappropriate behaviour (e.g. sexual)** | **Yes No**  **❑ ❑** |  |
| **Psychotic symptoms (e.g. hearing voices)** | **Yes No**  **❑ ❑** |  |
| **Interfamilial discord** | **Yes No**  **❑ ❑** |  |
| **Family history of mental health problems** | **Yes No**  **❑ ❑** |  |
| **Family history of self harm or suicide** | **Yes No**  **❑ ❑** |  |
| **Family history of substance misuse** | **Yes No**  **❑ ❑** |  |
| **Witness to violence** | **Yes No**  **❑ ❑** |  |
| **Criminal activity** | **Yes No**  **❑ ❑** |  |
| **School Exclusion/Non attendance** | **Yes No**  **❑ ❑** |  |
| **Lack of social support (e.g. family or friends)** | **Yes No**  **❑ ❑** |  |
| **Poverty/unemployment in family** | **Yes No**  **❑ ❑** |  |

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| **Name of Refer:** |  | **Date of Referral:** |  |
| **Received Date:** |  | **Assigned Worker:** |  |

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| **Thank you** |
| Thank you for taking the time to fill in this form. Our funders like to know how many people use our services. They also like to know basic numbers on age, gender and ethnic origin.  **Privacy / Confidentiality and Data Protection:**  We only pass on these numbers to our funders and not names or personal data. These forms will be collected and stored in our offices in Haringey. Information will only be shared within the guidelines of Mind in Haringey Privacy, Confidentiality policy, in line with our funders’ requirements and as stated in the 1998 Data Protection Act. Our filing cabinets are kept locked and our computers are password protected. |
| **Please send completed form to:**  **Email:** [Haringeywellbeingnetwork@mih.org.uk](mailto:Haringeywellbeingnetwork@mih.org.uk)  **Address:** Haringey wellbeing Network Administrator, Station House, 73c Stapleton Hall Rd, London, N4 3QF.  **Enquiries**: 0208 340 2474 (option 1). |