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**Young Person Referral Form**

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| **Referrer Details** | | | | |
| Organisation Name: | Contact Name: | | | |
| Address: | Office Number: | | | |
| Mobile: | | | |
| E mail address: | | | | |
| Date of referral: | | | | |
| Does the young person know you are referring them? | | | Yes | No |
| Have you asked permission from the young person to share their personal information? | | | Yes | No |
| **Young Person Details** | | | | |
| **Name:** | | **D.O.B** | | |
| **Address:** | | **Home Tel No:** | | |
| **Mobile:** | | **E mail address** | | |
| **N.I number** | | | | |

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| **AREAS OF CONCERNS**  Please tick the appropriate box/es | | | | | |
| Additional learning needs (Dyslexia/ADHD) |  | Drug/alcohol issues |  | Emotional/behavioural difficulty |  |
| Previous experience of sexual violence |  | Homeless |  | Lack of confidence |  |
| Care experienced |  | Living in poverty |  | Low Communication/Interpersonal Skills |  |
| Social Isolated |  | MCMC |  | Mental Health |  |
| Motivational issues |  | Physical Health/Disability |  | Young Carer |  |
| Young Parent |  | Young Offender |  | Low Vocational Skills/Qualifications |  |
| English as a second language |  | Literacy/numeracy |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| Does the young person have a long term disability, health problem or any learning difficulties?  **Yes**  - **Please tick all that apply below** **No** |
| If yes, are you registered disabled? **Yes**  **No** |
| |  |  | | --- | --- | | **DISABILITY TYPE**  Visual impairment  Hearing impairment  Disability affecting mobility  Other physical disability  Other medical condition (Eg. Epilepsy, Asthma, Diabetes)  Emotional/behavioural difficulties  Mental health difficulty  Temporary disability after illness (Eg. Post-viral, accident)  Profound complex disabilities  Aspergers Syndrome  Multiple disabilities  Other disability  Not known/information not provided | **LEARNING DIFFICULTY**  Moderate learning difficulty  Severe learning difficulty  Dyslexia  Dyscalculia  Other specific learning difficulty  Autism spectrum disorder  Multiple learning difficulties  Other LLDD  Not known/Not provided | |

**Please provide a brief outline of the reason for referral and tell how this person matches referral criteria**

* Young person involved in risk taking behaviour
* Unhealthy view of relationships
* Risk of sexual exploitation, violence or emotional abuse

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**Is the young person receiving any other support or working with any other agencies?**

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