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***Flourishing Famillies Referral Form*:**

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| --- | --- | --- | --- | --- | --- | --- |
| ***1. Consent:***   * Has the referrer met with the child or young person?  Yes / No * Has child / young person given consent to referral? Yes /  No * Has parent / guardian given consent to referral? Yes /  No * Has the parent/young person consented to transfer   of referral information to a CAMHS partnership agency if  assessed as more appropriate for their needs?  Yes / No   * Consent to store information on secure YPAS database Yes / No | | | | | | |
| ***2. Details of the child / young person:***  **Name:** Click here to enter text.  **Previous Surnames:** Click here to enter text.  **Address:** Click here to enter text.  **Postcode:** Click here to enter text.  **Main Tel No:** Click here to enter text.  **Other Tel No:**  Click here to enter text.  **NHS Number:** *(If not known YPAS will obtain)* Click here to enter text.  **Age:** Click here to enter text.  **Date of Birth**: Click here to enter a date.  **Ethnicity:** Click here to enter text.  **How would you describe your gender?** Click here to enter text.  **How did you hear about our services?**  Click here to enter text. | | | | | | |
| ***3. Parental Responsibility:***  ***Who has parental responsibility?*** Click here to enter text.  **Parent / Carer’s name:** Click here to enter text.  **Parent’s Address** (*if different from above)***:** Click here to enter text.  **Parent’s contact number:** Click here to enter text.  **Legal Status:**  Care of Parent Click here to enter text.  Care of Local Authority – Liverpool/Sefton/other  Section 20 Voluntary  Full Care Order  Interim Care Order  Care Order places at home  Child Protection Plan  Other Carer – give details below.  Details: Click here to enter text.  Safeguarding/Access: Click here to enter text. | | | | | | |
| ***4. Emergency contact:***  **Name of Emergency contact:** Click here to enter text.  **Relationship to you:** Click here to enter text.  **Telephone No:** Click here to enter text. | | | | | | |
| ***5. School Details:***  **School/Education provider:** Click here to enter text.  **Year group:** Click here to enter text.  **Key School Contact:** Click here to enter text.  **NEET:** Yes / No  **Is there a statement of educational needs or EHC plan?**  Y / N  **Is there an E-HAT open –** Yes / No  **Is the young person a Child in Need -** Yes / No  **Is the young person in employment -** Yes / No | | | | | | |
| ***6. Family: Please detail all relevant family members*** | | | | | | |
| ***Name*** | ***D.O.B*** | ***Relationship to Child*** | | | ***Possible support required*** | ***Contact details: phone number, address etc.*** |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | | | Click here to enter text. | Click here to enter text. |
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| Click here to enter text. | Click here to enter a date. | Click here to enter text. | | | Click here to enter text. | Click here to enter text. |
| ***7. Any other Professionals involved with any family member:***  **List all professionals with current contact details (phone and email)**  Click here to enter text.  **What has been the outcome with these services?**  Click here to enter text. | | | | | | |
| ***8. GP Details*** *(if not referrer)*  Are you registered? Yes  No  Don’t Know  Doctor’s Name: Click here to enter text.  Surgery Address: Click here to enter text.  Surgery Tel No: Click here to enter text. | | | | | | |
| ***9.Reason for Referral:***  **Brief description of the child/young person’s/family needs (Flourishing Families Criteria below use for guidance)**  Click here to enter text.  **What help and outcomes is the young person / family / professional expecting from this referral?**  Click here to enter text.  **List the impact the child/ young persons/families diffculities are having on their education or employment**  Click here to enter text.  **How long have these problems been an issue? Some years/months?**  Click here to enter text.  **Any identified risk factors?**  Click here to enter text. | | | | | | |
| ***10. Flourishing Families Criteria***  ***(This should include two or more of the following required experiences)*** | | | | | | |
| **Victimisation: Bullying, ASB, Violence, Community trauma** | | | | | | |
| **Domestic Abuse** | | | **Child/Adolescent to parent violence** | | | |
| **Parental Conflict** | | | **Witness of a violent incident** | | | |
| ***(Any of the following additional presentations)*** | | | | | | |
| **Sibling or parental offending** | | | | **Parental/carer mental health** | | |
| **Parent/carer alcohol or substance misuse** | | | | **Risk of entering or remaining in care** | | |
| ☐ **Child & Young Person’s mental health & Wellbeing inclusive of Neurodiverse Conditions** | | | | **Risk of school**  **and /or low school attendance** | | |
| ***11. Developmental Concerns:***  indicate whether the child / young person/family member has any specific learning difficulties (state and severity). This may include attention difficulties, social and communication difficulties, and delays in reaching milestones.  Click here to enter text. | | | | | | |
| ***12. Adaptations:***  Does the child / young person require any adaptations for attending appointments? E.g. venue, time, translation.  Click here to enter text.  Practitioner/Worker: Male Female Doesn’t matter**.**  ***13. Referrer Details:***  **Date:** Click here to enter a date.  **Name:** Click here to enter text.  **Role:** Click here to enter text.  **Organisation:** Click here to enter text.  **Address:** Click here to enter text.  **Telephone Number:** Click here to enter text.  **Email Address:** Click here to enter text. | | | | | | |
| ***14. Additional Information:***  (Any further information to support in understanding the family and their need)  Click here to enter text. | | | | | | |