**Children and Young Person’s Referral Form**

**Please fill out as much of the referral form as possible.**

**Date:** DD/MM/YYYY

**Referral Details:**

Name: Organisation:

Job Title: Tel No:

Email Address:

**Child/ren Details:**

Name: DOB:

Address: Gender:

Tel No:

**Health Visitor/School/Nursery Details:**

Name:

Contact Name:

Address:

Tel No:

**Parent/Carer Details:**

Name: DOB:

Address:

Tel No:

Email Address:

First Language:

Is an interpreter required? Y or No

**Safe to Contact By:**

**(IMPORTANT – We cannot accept referrals without the information below. Please indicate Yes or No and add extra contact details where required)**

**Telephone:** Y or N **(delete where appropriate)**

**Text Message** Y or N **(delete where appropriate)**

**Post:** Y or N **(delete where appropriate)**

**Email Address:** Y or N **(delete where appropriate)**

**Emergency Contact:** Y or N **(delete where appropriate)**

**Referring Agency:** Y or N **(delete where appropriate)**

**Emergency Contact Details:**

Name: Relationship to Child/ren:

Tel No:

**Other Agencies/Professionals:**

Please detail below any other services or professional’s involvement with the CYP:

*For example, Barnardo’s, Quarriers*

**Social Work Involvement:**

Name of Allocated Worker Area Team:

Tel No: Email:

Are the Children on the Child Protection Register? Y or N

**Agency Referral:**
**Please detail below what support do you consider the Woman and/or Children require from GEWA providing as much detail as possible?**

(Inset referral information here)

**Coping Methods:**

Please provide details of any coping mechanisms that the child/young person may use:

|  |  |
| --- | --- |
| Coping Method | Additional Information (Please detail below) |
| **Exercise** |  |
| **Peer Support** |  |
| **Bedwetting** |  |
| **Self-Harm** |  |
| **Alcohol/Substance misuse** |  |
| **Unhealthy Relationships: Peers/Gang** |  |
| **Dating Abuse** |  |
| **School Refuser** |  |
| **Bullying** |  |
| **Sexual Health** |  |
| **Eating Disorders** |  |
| **Additional information** |  |

**Agency Declaration:**

I declare that the information I have given is a full and honest account of my knowledge regarding the person(s) concerned.

Signed:

Print Name:

Date:

**It is considered best practice to share relevant information with partner agencies when necessary in order to provide a holistic and collaborative approach to support. In order for us to provide this information we require consent from parent/main carer from under age 14 and from service user age 14 and over.**

Parent/Carer signature: Date:

Service user signature: Date:

**Equal Opportunities Monitoring Form**

It is Glasgow East Women’s Aid policy to treat all job Women who are employed in the service and the Women who use the service fairly and equally, regardless of their sex, trans-gender status, sexual orientation, religion or beliefs, marital status, civil partnership status, age, race, colour, nationality, national or ethnic origins or disability.

The organisation needs your help and co-operation to enable it to do this but filling in this form is **voluntary**.

**Gender:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Prefer not to say 🗆

**What is your ethnicity?**

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please detail below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Prefer not to say 🗆

**Do you consider yourself to have a disability or health condition?**

Yes🗆 No 🗆 Prefer not to say 🗆

**What is your sexual orientation:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ orPrefernot to say 🗆

**What is your religion or belief? Please detail below**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ orPrefernot to say 🗆