

Referral form The YP Project

Please complete this referral as fully as possible. Failure to do so will result in a delay in us being able to process the referral.

Referrer details

Your name and relationship to the person being referred:		Today's date:	
Your email address:		Your phone number:	
Please confirm that consent has been gained for this referral:	<p>Young Person's Consent:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Parent Consent:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Please note that we cannot accept referrals without BOTH parent and young person's consent.</p>		
Please describe your involvement with the family:			
Please advise the status of any safeguarding measures/child protection plans:			
Is there/has there been CAMHS involvement?			
Is this referral relating to abuse toward parent/carer or intimate partner or both?			

Other Professionals Involved			
Name	Phone Number	Email	Organisation & Role (State what members of the family they're working with)

Details of young person being referred			
Name:		D.O.B:	
Email:		Phone:	
Support required for engagement (Interpreter, language, literacy, etc):		Address:	
Gender:		Sexuality:	
Ethnicity:		Religion:	
Previous criminal convictions, injunctions, cautions or arrests for domestic abuse:		Are there ongoing care proceedings?	
Current criminal proceedings or injunctions concerning domestic abuse:			
What school or college does the young person attend?			
Is the young person in a relationship?			
Physical Disabilities or	(If yes, please describe)		



Please provide details of all known incidents and risk factors. (Please mention if any incidents led to any police callouts)

Please provide a description of any strengths, interests or positive interactions with the young person. Are there adults/relatives with which they have a positive relationship. If appropriate please provide their contact information as well.

How did you hear about The YP Project?

Parent/Carer or Partner of Young Person being referred			
Name:		D.O.B:	
Email:		Phone:	
Gender:		Sexuality:	

Ethnicity:		Religion:	
Address:		Support required for engagement (Interpreter, language, literacy, etc.)	
Physical Disabilities or Mental health concerns:	(If yes, please describe)		
Substance misuse concerns:	(If yes, please describe)		
Are there any risks to professionals that you are aware of?	(If yes please describe)		
Has the parent/carer been impacted by DV in the past? Has there been DV in the family?	(If yes please describe)		
Please confirm that you have consent to share the person described above's details.			
Yes <input type="checkbox"/> No <input type="checkbox"/>			

If there is another parent/carer involved with the young person or family, please give their details below:

Parent/Carer or Partner of Young Person being referred			
Name:		D.O.B:	
Email:		Phone:	
Gender:		Sexuality:	

Ethnicity:		Religion:	
Address:		Support required for engagement (Interpreter, language, literacy, etc.)	
Physical Disabilities or Mental health concerns:	(If yes, please describe)		
Substance misuse concerns:	(If yes, please describe)		
Are there any risks to professionals that you are aware of?	(If yes please describe)		
Has the parent/carer been impacted by DV in the past? Has there been DV in the family?	(If yes please describe)		
<p>Please confirm that you have consent to share the person described above's details.</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>			

Please return this form to: info@jenkinscentre.org.
Once we have received your referral we will confirm safe receipt via email. Should you wish to send the referral via CJSM to:
Jenkins.Centre@freeva.cjism.net