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| --- | --- |
| **For office use only** | |
| **CLIENT NUMBER** |  |



**DATE: ………………………………………………..**

**NEW YOUNG PERSON REFERRAL**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | | | | | | |
| **FIRST NAME:** | |  | | | | | | | | | | | |
| **SURNAME:** | |  | | | | | | | | | | | |
| **DATE OF BIRTH:** | |  | | | | | | | | | | | |
| **ADDRESS:** | |  | | | | | | | | | | | |
| **TELEPHONE:** | |  | | | | | | | | | | | |
| **EMERGENCY CONTACT:** | |  | | | | | | | | | | | |
| **GP DETAILS:** | |  | | | | | | | | | | | |
| **SCHOOL DETAILS:** | |  | | | | | | | | | | | |
| **EMAIL:** | |  | | | | | | | | | | | |
| **BOROUGH:** | |  | | | | | | | | | | | |
| **IS IT OK IF WE…** | | **CALL?** |  | | | | **LEAVE A VOICEMAIL?** | | | |  | | |
| **TEXT?** |  | | | | **EMAIL?** | | | |  | | |
| **HOW DO THEY DESCRIBE THEIR GENDER?** | | | | |  | | | | | | | | |
| **IS THEIR GENDER THE SAME AS THEY WERE ASSIGNED AT BIRTH?** | | | | | | | | | **YES** |  | | **NO** |  |
| **HOW DO THEY DESCRIBE THEIR SEXUAL ORIENTATION?** | | | | | | | | | | | | | |
| **HETEROSEXUAL** | **GAY** | **LESBIAN** | | **BISEXUAL** | | **ASEXUAL** | | **OTHER:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **HOW DO THEY DESCRIBE THEIR ETHNIC ORIGIN?** | | | | | | | | | | | | | |
| **(please state):** | | | | | | | | | | | | | |
| **DOES THE CLIENT HAVE ANY DISABILITIES OR NEURODIVERSITIES?** | | | | | | | | | **YES** |  | | **NO** |  |
| **IF YES, WHAT IS THE NATURE OF THE DISABILITY OR NEURODIVERSITY?** | | | | | | | | | | | | | |
| **(please state):** | | | | | | | | | | | | | |

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| **REASON FOR REFERRAL** | | | |
| **Please indicate whether you believe the following risk indicators are present:** | | | |
| Alcohol/drug use  At risk of sexual exploitation  Behavioural difficulties  Emotional difficulties  Evidence of self-harming  Family breakdown  Has been missing from home  Has had unplanned pregnancy  History of abuse (DV, sexual, assault) | | Housing (supported or homeless)  Involved with Youth Offending Service  Is a teenage parent  Lack of adult support  Lack of appropriate boundaries  Lack of aspirations  Learning difficulty/disability | Looked After Child  Low self-esteem/confidence  Older boyfriend/girlfriend/peers  Parental teenage pregnancy  Poor education attendance/NEET  Risky sexual behaviour  Wants to become pregnant |
| Other risk: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Please indicate the level of risk for this young person based on the information you have provided:** | | | |
| Low risk | Medium risk | | High risk |
| **Please give details on client’s family status:** | | | |
| **Is the client subject to a child protection plan/order? If so, please give brief details:** | | | |
| **If the client is a looked-after child please provide a brief placement history if available:** | | | |
| **Is the client currently taking any prescription medication? If so please give details:** | | | |
| **Is the client receiving psychiatric care within secondary mental health such as CAMHS? If so, please give details of psychiatrist/psychologist/therapist so consent for counselling can be sought:** | | | |
| **Please provide any further details on reasons for referral:** | | | |

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| **NAME OF REFERRAL ORGANISATION:** |
| **NAME:**  **POSITION:**  **CONTACT DETAILS:** |
| **CLIENT CONSENT:** |
| **I give consent for the person/organisation named above to discuss the concern about my wellbeing with Spectra and for Spectra to contact me to explore support.**  **CLIENT SIGNATURE: Date:** |

**PLEASE RETURN FORM TO:** [**young@spectra-london.org.uk**](mailto:young@spectra-london.org.uk)

**SPECTRA, ST CHARLES CENTRE FOR HEALTH AND WELLBEING, EXMOOR STREET, LONDON W10 6DZ**

**FOR SELF-REFERRAL OR MORE INFORMATION, PLEASE CONTACT:**

**SPECTRA FREEPHONE: 0800 567 8302 (020 3322 6920)**

**SPECTRA WANDSWORTH COUNSELLOR: 07712404252**

**MERTON YOUNG PEOPLE’S SEXUAL HEALTH COORDINATOR: 07712 404251**

**WANDSWORTH RELATIONSHIPS, SEX & IDENTITY MENTOR: 07731 012072**