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

 

**DATE: ………………………………………………..**

**NEW YOUNG PERSON REFERRAL**

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| **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**

**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**