

**Wellbeing Connect Services**

**& Edmonton Community Partnership: Children/Young Person’s**

***#WhatIf* Project**

**CONFIDENTIAL REFERRAL FORM**

Referrer’s Details:

|  |  |
| --- | --- |
| Name of Referrer |  |
| Address  Telephone  Fax (If applicable)  Email Address |  |
| Date of Referral |  |
| Relationship to CYP |  |
| Has this referral been discussed with the CYP |  |

Any queries relating to this case please contact:

Wellbeing Connect Services: **Enfield**

Email to: **info@wellbeingconnectservices.org**

Telephone: **02088032200; mob: 07711128997**

Child, Young Person Personal Details

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Telephone Number |  |
| Date of Birth |  |
| Sex |  |
| Gender Identity |  |
| Email address (where applicable) |  |
| Ethnicity |  |
| Religion |  |
| First Language |  |
| Emergency Contact Details |  |
| Disabilities |  |

Parent / Guardian / Carer Details

|  |  |
| --- | --- |
| Person with Parental Responsibility |  |
| Relationship to Child / Young Person |  |
| Address |  |
| Phone |  |
| Email |  |
| Preferred Contact method |  |
| Any other children within the family/household requiring support? |  |
| Consent/Approval to use data provided? |  |
| Parent/ Guardian signature | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Referring Agency Details (if applicable)

|  |  |
| --- | --- |
| Referring Agency Name |  |
| Referring Agency Contact |  |
| Address |  |
| Phone |  |
| Email |  |

The Situation

|  |  |
| --- | --- |
| As described by the CYP, Parent/Guardian/Carer or Referring Agency |  |

Child/Young Person’s Needs Assessment

|  |  |
| --- | --- |
| Additional Information from Referrer |  |
| Description of Welfare Concerns |  |
| Needs Identified (From pre-defined list) |  |
| Details of other Needs not listed above |  |
| Description of Protective Structures |  |
| Analysis & Rationale for Support Packages Offered |  |

History and Current Issues

|  |  |
| --- | --- |
| Are you aware of any risks (either to self or staff) associated with this CYP? Please provide details |  |
| Does the CYP have any physical health problems? Please provide details |  |
| Does the CYP have any substance use or misuse issues? Please provide details |  |
| Please provide details of any family challenges (for instance - violence in the home, parenting issues, financial concerns) |  |
| Is the CYP at risk of suicide or self-harm? Please provide details |  |

Priority Groups

|  |  |  |  |
| --- | --- | --- | --- |
| **Group 1:** Children and families from BAME communities | |  | |
| **Group 2:** Children with Special Educational Needs and Disabilities who are impacted by lockdown / COVID-19 | |  | |
| **Group 3:** Families with children under 5 years – (particularly those under 2) | |  | |
| **Group 4:** Children who are Young Person from other communities | |  | |
| **Group 5:** Children at risk of exploitation outside of the home | |  | |
| **Group 6:** Children requiring mental health and wellbeing support |  | |

|  |  |
| --- | --- |
| Please select one of the following that young person needs support with: |  |
| 1. Emotional / Mental Wellbeing |  |
| 2. Financial & Welfare |  |
| 3. Education |  |
| 4. Self-esteem |  |
| 5. Relationships (Friends, Family, etc.) |  |
| 6. Career |  |
| 7. Behavior |  |
| 8. Other, Please Specify: |  |

|  |
| --- |
| Wellbeing Connect Services (WCS)Data Protection Participant Enrolment Declaration The information collected on this referral form and regarding your participation through this project will be shared with appropriate funding agencies as evidence of your referral. WCS will also use the information collected on this referral form to produce reports to a variety of interested parties in a statistical format only, Your data will be retained until the end of the project for these purposes and as legally required by law.  **Declaration**  I consent to my data being stored and used as described above for the purposes of the project and to provide me with services.  Signed ……………..…………………………………… Date ……………..………  To be signed by CYP/ Parents / Guardian / Referrer |

**Service Delivery For official use only (WCS staff only):-**

The following services have been identified from Initial Assessment for **Wellbeing Connect Services** to provide.

|  |  |
| --- | --- |
| **Online digital support** | **Units** |
| **Package 1** - Advice and signposting |  |
| **Package 2** - Therapeutic support |  |
| **Package 3** - Group work |  |
| **Package 4** -Advocacy support |  |
| **Package 5** -Parent support |  |