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| **ICR CYP e-Therapy Referral Form****Please note, we require consent from the client to process the referral, if the client has not given you permission, do not submit the referral.****Completed referrals should be emailed to: etherapy.admin@selfhelpservices.org.uk** |
| **Referral Date** |  | **Referrers name and contact details** |  |
| **Referrer / setting\* (please tick one):** |
| Manchester Early Help Hub NORTH |  | Salford Early Help Central Broughton |  |
| Manchester Early Help Hub CENTRAL |  | Salford IYSS |  |
| Manchester Alonzi House |  | Salford Ed Start PRU |  |
| Manchester Moss Side MYL PRU |  | Salford Clifton PRU |  |
| Manchester Levenshulme Music Stuff PRU |  | Salford Broadwalk PRU |  |
| Manchester Openshaw Music Stuff PRU |  | **Other** – please state |  |
| **\*Please note, we can only accept referrals from the following services, based in either Salford or Manchester:*** 42nd street (ICR & Core service)
* Mind Manchester & Salford
* Early help Services
* School co-ordinators
* Prince’s Trust
* Safe Zones
* Pupil Referral Units (Pru’s)
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| Please confirm that the young person consented to this referral:  | Yes |  | No |  |
| Please confirm that young person consents to contacting parent/caregiver\*:*\*Please note, we require consent of the caregiver for anyone under 16 years of age to process the referral* | Yes |  | No |  |
| **Young Person’s Details** |
| Name: |  | Date of Birth: | DD / MM / YYYY |
| Address: |  |
| Postcode: |  | You will find your NHS number on:* A medical card
* A letter from your GP
* A printed prescription
 |
| NHS Number (if known): |  |
| Landline Number: |  | We will try to contact you by telephone unless otherwise advised. If possible, please provide a mobile number in addition to a landline.  |
| Mobile Number: |  |
| Email Address: |  |
| **How can we get in touch with you? (Young Person)** |
| Please tick (a), (b), (c), (d), (e) if you provide consent  | 1. leave a message with someone answering my phone
 | □ |
| 1. leave a message on my answering machine
 | □  |
| 1. send reminders via text message to your mobile
 | □ |
| 1. send a message via email
 | □ |
| 1. prefer to contact you through your parent/caregiver (please provide details below)
 | □ |
| **Parent/ Caregiver/ Next of kin/ Emergency contact**  |
| Name: |  | We will try to contact you by telephone unless otherwise advised. If possible, please provide a mobile number in addition to a landline. |
| Address: |  |
| Postcode: |  |
| Landline Number: |  |
| Mobile Number:  |  |
| Email Address: |  |
| **How can we get in touch with you? (emergency contact)** |
| Please tick (a), (b), (c), (d), if you provide consent  | a) leave a message with someone answering my phone | □ |
| b) leave a message on my answering machine  | □ |
| c) send reminders via text message to your mobile | □ |
| d) send a message via email | □ |
| **GP’s Details (Young Person)** |
| **GP Name:** |  | To find your GP address go to <http://www.nhs.uk/service-search> |
| **Practice Address:** |  |
| **Postcode:** |  |
| **Practice Tel No:** |  |
| We may need to notify your GP that you are accessing our service if we feel that you or someone else is at risk of harm. Information will only be shared on a need to know basis and we will endeavour to discuss this with your prior to doing so.  | **Yes, I give Self Help permission to contact my GP** □  |

**Do we have permission to contact the young person? Yes/ No**

**Please provide further details about making contact:**(If there are any ways in which we **should not** make contact, if there are any issues with phone credit or if they should only be contacted via parent/carer, also include any preferred method agreed by the young person.

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| **About Young Person** |
| What is their gender?  |  |
| What is their ethnic origin? |  |
| What is their religion? |  |
| Is English their first language? | Yes  | □  | *If no, please give details.* |
| No  | □  |
| Do they have any problems speaking, reading or writing English? | Yes  | □  | *If yes, please give details.* |
| No  | □  |
| Do they have any disabilities we should be aware of? | Yes | □ | *If yes, please give details.* |
| No | □ |
| Do they have any long-term health conditions?  | Yes  | □  | *If yes, please give details; e.g. visual, speech, hearing, mobility*  |
| No  | □  |
| Are they or their partner currently pregnant; or have they had a baby in the last 12 months? | Yes  | □  | *If yes, please give details.* |
| No  | □  |
| What is their sexual orientation? | *Please give details.* |

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| Is the young person a Young Carer for a parent/carer or family members? | No |  | Yes |  | Prefer not to say |  |

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| --- | --- | --- | --- | --- |
| Is young person a Looked after Child?  | No |  | Yes |  |
| Is there a Private Fostering Arrangement in place?  | No |  | Yes |  |
| Is young person leaving Care?  | No |  | Yes |  |

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| Does the young person have any criminal convictions? | No |  | Yes |  | Prefer not to say |  |

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| **Please provide details and named contacts of all agencies that are currently supporting the young person and/or their family and what their involvement is?**e.g.School contact, Young Carers, YOS, Social Care, Youth Services, CAMHS, GP) |
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**Does the young person’s behaviour ever present a risk to themselves or others?**

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| --- | --- | --- | --- | --- |
| Does the young person present any risk to others? | No |  | Yes |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Does the young person self-harm? | No |  | Yes, sometimes |  | Yes, often |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Do they have suicidal thoughts? | No |  | Yes, sometimes |  | Yes, often |  |

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| --- | --- | --- | --- | --- |
| Has the young person had thoughts of suicide in the past 2-3 weeks that they have wanted to act upon? | No |  | Yes, sometimes |  |
| Yes, often |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Have they previously attempted suicide? | No  |  | Yes, once  |  | Yes, more than once |  |

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| If yes, when was this? |  |

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| **Please give further details of all that have been ticked yes:**E.g. previous / current CAMHS involvement; presentation at A&E; any existing safety plans / crisis support in place, known triggers. |
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**Medication / Alcohol / Substance Questions**

**Prescribed Medication**

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| --- | --- | --- | --- | --- |
| Are they currently taking any prescribed medication? | No |  | Yes |  |
| If YES please record name, purpose, dose and compliance for each medication: |

 **Non-prescribed Medication**

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| --- | --- | --- | --- | --- |
| Are they taking over the counter or non-prescribed medication or drugs?  | No |  | Yes |  |
| If Yes please record name, purpose, dose / amount and frequency for each medication / substance |
| Do you feel life would be unmanageable without taking this?  | No |  | Yes |  |

**Alcohol**

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| How often do they have a drink containing alcohol? |
| **Never****(0)** | **Monthly or less (1)** | **2 to 4 times a month (2)** | **2 to 3 times a week (3)** | **4 or more times a week (4)** |

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| **What does the young person say they want to get from the support?**e.g.Goals and focus of support, if the young person found the support useful what would they notice that would be different? |
| *Please give details:* |

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| **Is there anything else we need to know?**e.g. learning/physical disabilities, worker preference, translator, behaviours or changes you are aware of which indicate specialist support.  |
| *Please give details:* |

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