**TDAS CYP Service**

Completed forms can be returned via email to jenny.campbell@tdas.org.uk and samantha.hallam@tdas.org.uk

**All referrals must be sent password protected.**

**Please only refer one child per form**

**PLEASE ENSURE CONSENT IS GAINED BY PARENT/CARER & YOUNG PERSON TO MAKE THIS REFERRAL**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referred By:** |  | **Date Referred**  |  |
| **Role:** |  |
| **Referral contact:** |  |
| **Children Services involvement?** | Y/N  | **Level of involvement:** |  |
| **Social worker details:** |   |
| **Has the child/Young person & parent consented to this referral?**  |  |
| **I understand that information about me will be held confidentially unless I give my permission for it to be shared with others.** |  |
| **Please tick which service you are referring to:** |
| **RSPACE group**  |  | **1-2-1 support**  |  |  **Parenting Programme (Internal referrals only)** |  | **Children & Family Worker (internal referrals only)** |  |
| **Name of Child/Young Person****(1 CYP per form)** |  | **DOB** |  |
| **Sexuality**  |  | **GENDER** |  |
| **Current address** |  |  **Postcode** |  |
| **Parent’s details**  |  | **Contact name & number (Young Person’s number can be provided):** |  |
| **Child’s school** |  | **Safe to contact? (call, text, leave a message)** |  |
| **Does the child/young person have contact with the perpetrator?** |  |
| **Perpetrators relationship to child/young person:** |  |
| Ethnicity |  |
| Child’s first language |  |
| Child’s religion |  |
| **PLEASE TICK ALL THAT APPLY:** |
| Mental health needs |  | BAME needs e.g. language/ dishonour based abuse/FGM  |  | Learning disability |  | Substance misuse - alcohol |  |
| Pregnant |  | Self-harm / attempted suicide |  | Physical ill-health |  | Substance misuse - drugs |  |
| Risk from perpetrator/ other people |  | LGBT needs |  | Gang involvement |  | Anything else? |  |
| Please provide details: |  |
| **Other agencies involved:**  |
| Name & agency | Contact |
|  |  |
|  |  |
|  |  |
| **Reasons for referral:**  |
| Has the child been exposed to DA? (witnessed, overheard, present in the house when DA has occurred) | **YES** |  | **NO** |  |
| Is the young person in their own abusive relationship? | **YES** |  | **NO** |  |
| **Please provide details of History of DA and Involvement with the family:**  |
| (please provide as much information about the child’s experience of domestic abuse as possible: Stalking and harassment, severity of domestic abuse incidents, recent incidents, child’s exposure to DA |
| **How has the child or young person been affected by the DA they have been exposed to? (please detail any substance misuse, mental health or self-harm)** |
|  |
| **Please specify what support you would like for the child or young person you are referring:**  |
|  |