**TDAS CYP Service**

Completed forms can be returned via email to [jenny.campbell@tdas.org.uk](mailto:Jenny.campbell@tdas.org.uk) and [samantha.hallam@tdas.org](mailto: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 | | | | | | | | | | | | | |
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| **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:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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