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| **T3 STaRS YOUNG PERSON’S REFERRAL FORM** | | | | | |
| **Essential Criteria for Acceptance of Referral:**  **(if you answer ‘No’ to any of the questions below, please email us to discuss further)**  **\*Is the young person aware of this referral? Yes  No  \*Do they agree to this referral? Yes  No** | | | | | |
| **\*Are the young person’s parents/carers aware of this referral? Yes  No**  **(please note: the parental consent form is required for a young person under the age of 13 years)** | | | | | |
| **SECTION 1 - REFERRER’S DETAILS** | | | | | |
| Name: | | Organisation: | | Email address: | |
| Contact Tel No: | | Role: | | Person to contact in your absence: | |
| Address: | | | | | |
| **SECTION 2 - CLIENT DETAILS** | | | | | |
| Name: | | Ethnicity: | | Gender Experience / Identity / Pronouns used: | |
| Address:  Postcode: | | D.O.B  Age: | | Young Person’s Education / employment Status:  Name of school / college: | |
| Young Person’s Contact Tel No: | | Parent’s Name and contact telephone No: | | | |
| Is the young person receiving mental health treatment?  **Yes  No**  Professional working with client: | | Does the young person have learning / Disability needs?  Please provide details:  Is an interpreter or signer required? **Yes  No**  If so, for please provide details: | | | |
| \*Where would the young person like to be seen? | | \*Are there any risks in visiting the home? **Yes  No**    Please record detail below: | | | |
| \*Can the young person be contacted at home? **Yes No** | | \* Who does the young person live with? | | | |
| **SECTION 3 - REFERRAL DETAILS** Tick the relevant referral request.  Please record information in as much detail as possible as this helps the service to determine risk levels | | | | | |
| **YP SUBSTANCE USE REQUEST** | | | | | |
| **Substances currently being used.** | **Route- smoke, oral, snort** | | **How much - £, bags, cans, bottles, units** | | **How often - daily, 2/7, weekly, binge** |
|  |  | |  | |  |

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| --- | --- | --- | --- |
| **HIDDEN HARM REQUEST** | | | |
| **Is the young person aware of the substance use within the family?** | **What impact does the substance use have on the young person?** | **What substances are being used?** | **What contact does the young person have with the family member using substances?** |
|  |  |  |  |
| **GROUP WORK REQUEST** | | | |
| **Any details / risks we need to be aware of in group environment?** | | | |
| **SECTION 4 – SAFEGUARDING CONCERNS** | | | |
| **Is the young person on a CP PLAN? Yes  No**  **Is the young person on a CIN Plan? Yes  No**  **Is the young person a Looked After Child? Yes  No**  Social Workers name and contact details name:  **Please detail reason for involvement or Safeguarding concerns:** | | | |
| **SECTION 5 – EXPLOITATION / CCE & CCE** | | | |
| **Has a Risk Factor Matrix been completed? Yes  No**   **Are they discussed at MACE Yes  No**    **Risk level on Matrix Low  Medium  High**  **CCE  CSE  DUAL**    **PLEASE ATTACH RFM WITH REFERRAL FORM** | | | |
| **SECTION 6 - OFFENDING** | | | |
| Is the young person involved in criminal activity or at risk of becoming involved in criminal activity **Yes**  **No**    Is the young person working with the Youth Offending Service **Yes  No**  **Case Manager’s Name:**  **Please detail offence type/s, & additional information** | | | |
| **SECTION 7 – STRENGTHS AND POSITIVE FACTORS FOR THE YOUNG PERSON** | | | |
| **Please record what strengths the young person has and the protective factors in place for them:** | | | |
| **SECTION 8 – ADDITIONAL INFORMATION** | | | |
| **Identified Risks: Safeguarding, Risks to home visiting, Risk to worker, Exploitation, overdose, injecting, offending, physical/mental health issues, binge use, & Any Other Relevant Information** | | | |

**Please submit your referral: STARSYP@mpft.nhs.uk**