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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.BAge: | 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?** |
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| **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**