Referral Form

Social Worker Questions

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| **Personal Details** | | | | |
| Name of child/ Young Person:  (Full name including middle names) | |  | | |
| D.O.B: | |  | | |
| Current Address and postcode: | |  | | |
| National Insurance Number: | |  | | |
| Height: | |  | | |
| Weight (Approx.): | |  | | |
| **Background and Needs** | | | | |
| Social Worker, Name and details: | |  | | |
| Reason for referral: | |  | | |
| Is the child/ young person currently in a care home: | |  | | |
| Reason for breakdown at current placement: | |  | | |
| Child/ young person’s background: | |  | | |
| Information about the child/ young person’s family: | |  | | |
| Contact arrangements with the family/ Visitation arrangements: | |  | | |
| Has a mental health capacity assessment ever been conducted:  *(Please tick ✓ as appropriate)* | | Yes  No  *(Please list and attach details of Assessment or Reports)* | | |
| Legality/ Which section of the Court Order: | |  | | |
| Do they have an Educational, Health Care Plan (EHCP)? | | YES  No | | |
| Does the child/ young person have any Diagnosis?  *(Please tick ✓ as appropriate)* | | | | |
| Autism (ASD/ASC) | Attention hyperactivity Disorder (ADHD) | | | Opposition Defiance Disorder (ODD) |
| Obsessive Compulsive Disorder (OCD) | Social, emotional and mental health | | | Speech, language and communication needs/difficulties |
| Visual impairment | Hearing impairment | | | Moderate learning difficulty |
| Severe learning difficulty | Other, Please Specify | | |  |
| Current or previous behaviour’s that the child/ young person has displayed? | | | | |
| Hitting/punching somebody else | Self-harm (including punching a wall in frustration) | | | Damage to property |
| Kicking | Spitting | | | Head- Butting |
| Throwing small items (such as books, pens etc.) | Throwing large items (such as chairs, tables etc.) | | | Carries a weapon (or has been known to) |
| Used a weapon on another person before | Arson, actual or attempt | | | Discriminatory language |
| Racist language | Extremist views/ idealisation | | | Absconding |
| Alcohol misuse | Drug misuse | | | Smoking/ Vaping |
| Other, Please Specify: | | | | |
| **Education** | | | | |
| Name of current school or college: | |  | | |
| Address: | |  | | |
| Educational status/history: | |  | | |
| Telephone Number: | |  | | |
| Email contacts: | |  | | |
| **Transport** | | | | |
| Transport details (If applicable): | |  | | |
| **Medical/ Therapy Information** | | | | |
| Name of GP and Surgery: | |  | | |
| Surgery Address: | |  | | |
| Telephone Number: | |  | | |
| Email Address: | |  | | |
| Any past or present medical issues: | |  | | |
| Allergies: | |  | | |
| Medication currently being taken: | |  | | |
| Optician, address, last visit, outcome: | |  | | |
| Dentist, address, last visit, outcome: | |  | | |
| Therapy needs/ appointments: | |  | | |
| Do they have any sensory issues relating to; sound, taste, feel, light, smell? | |  | | |
| **Independent Skills** | | | | |
| Will the child/ young person be independent in the following: | | | | |
| Washing themselves:  Yes  No | Dressing themselves:  Yes  No | | | Washing their clothes:  Yes  No |
| Cleaning their room:  Yes  No | Managing money:  Yes  No | | | Cooking for themselves:  Yes  No |
| Access the internet safely:  Yes  No | Completing household chores:  Yes  No | | | Travelling independently:  Yes  No |
| Is there anything else that is important that we should know before working with this child/ young person: | | | | |
| **Other Key information** | | | | |
| Do the/ will they have friends in the Local Community? | | |  | |
| Can they get public transport? | | |  | |
| Have they got any specific hobbies? | | |  | |
| Do they have a phone/ laptop or console that they will be bringing with them? | | |  | |
| How much belongings do they have/ will they bring? | | |  | |
| What are the weekly professional meeting expectations? | | |  | |
| Current staffing ratio? | | |  | |
| Any other relevant information we should know?  (Team to input key lines of enquiry based from the original referral) | | |  | |

Young Person Questions

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| **Personal Details** | |
| Name: |  |
| What do you like about your current placement? |  |
| Which and why do you like certain staff members? |  |
| What are your hobbies and interests? |  |
| What are your favourite colours? |  |
| Are you able to be safe on a; train, bus, taxi, tram? |  |
| What do you enjoy? |  |
| What are you like with education?  What do you find difficult about education? |  |
| What would motivate/incentivise you? |  |
| What makes you feel calm? |  |
| What are your behaviours? |  |
| What are your triggers? |  |
| What kind of foods do you not eat? |  |
| Do you have any sensory issues relating to; sound, taste, feel, light, smell? |  |
| What is your bedtime routine? |  |
| What is your bath time routine? |  |

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| Current or previous behaviour’s that you have displayed? | | |
| Hitting/punching somebody else | Self-harm (including punching a wall in frustration) | Damage to property |
| Kicking | Spitting | Head- Butting |
| Throwing small items (such as books, pens etc.) | Throwing large items (such as chairs, tables etc.) | Carries a weapon (or has been known to) |
| Used a weapon on another person before | Arson, actual or attempt | Discriminatory language |
| Racist language | Extremist views/ idealisation | Absconding |
| Alcohol misuse | Drug misuse | Smoking/ Vaping |
| Other, Please Specify: | | |

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| --- | --- | --- |
| **Independent Skills** | | |
| Are you independent in the following: | | |
| Washing yourself:  Yes  No | Dressing yourself:  Yes  No | Washing your clothes:  Yes  No |
| Cleaning your room:  Yes  No | Managing money:  Yes  No | Cooking for yourself:  Yes  No |
| Access the internet safely:  Yes  No | Completing household chores:  Yes  No | Travelling independently:  Yes  No |
| Is there anything else that is important that we should know before working with this child/ young person: | | |