Referral Form

Social Worker Questions

|  |
| --- |
| **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

|  |
| --- |
| **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? |  |

|  |
| --- |
| 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: |

|  |
| --- |
| **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: |