

## REFERRAL OF A YOUNG PERSON

Suite 4, 2 Church Street, Crewkerne, Somerset TA18 7HR

Name of Young Person:		Gender:	
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Name and Address of Referring Authority: (please include postcode)

Name of Social Worker responsible:			
Contact Number:		Out of Hours; EDT number:	

Additional Material Attached: (if so please give details)

Signed:		Date:	
Name:		Status:	









Name of Young Person:	
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Give details of any known or suspected past offences by the young person, including any matters currently in process of investigation or trial:

Date(s)	Details of Offence	Suspected only or court case, ref and date:

Give details of any other known or suspected behaviour by the young person which might be a cause of danger to the young person, other people or property: (Include details of any known or suspected substance abuse/addiction)

Date(s)	Details:

Name of Young Person:	
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**SECTION E: HEALTH & MEDICAL FACTORS**

**Young person's current or most recent practitioners:**

<b>G P Name:</b>	<b>Dentist Name:</b>	<b>Optician Name:</b>
<b>Address:</b>	<b>Address:</b>	<b>Address:</b>
<b>Tel:</b>	<b>Tel:</b>	<b>Tel:</b>

State whether the young person is known to have had any of the following: (please tick)

- |                                      |   |  |                                 |
|--------------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Measles       | <input type="checkbox"/> TB     |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Meningitis    | <input type="checkbox"/> Polio  |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Tetanus       | <input type="checkbox"/> Mumps  |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Eczema |

Does the young person smoke:  OR Drink alcoholic drinks:   
 Immunised against: (please tick)

- |   |   |                                    |                                |
|---|---|------------------------------------|--------------------------------|
| <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Measles        | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Polio |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Tetanus   |                                |

Has the young person had a BCG:  Skin Test?  Injection?

Is the young person believed to have any of the following? If so please give details below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Phobias                        | <input type="checkbox"/> Incontinence         |
| <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Special Dietary Needs          | <input type="checkbox"/> Congenital Condition |
| <input type="checkbox"/> Sight/Hearing Impairment | <input type="checkbox"/> Other Gynaecological Complaint |   |

Details of any thing ticked in above section: (or continue on separate sheet)
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Is it possible/likely/known that the young person is a high risk with respect of the following: (Please tick)

- |           |                          |          |                          |        |                          |       |                          |
|-----------|--------------------------|----------|--------------------------|--------|--------------------------|-------|--------------------------|
| HIV       | <input type="checkbox"/> | Possible | <input type="checkbox"/> | Likely | <input type="checkbox"/> | Known | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | Possible | <input type="checkbox"/> | Likely | <input type="checkbox"/> | Known | <input type="checkbox"/> |

**INITIAL QUESTIONS**

**Disclosure information from Social Services failure to answer any questions will result in the placement being automatically refused until full information is received in writing.**

Name of Young Person:	
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**Does the local Authority require the following services?**

**PLEASE TICK BOX THAT APPLIES:**

**NO      YES**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Short Term assessment placement  |
| <input type="checkbox"/> | <input type="checkbox"/> | Assessment for preparation of court reports  |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological assessment through the agencies own consultants                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment  |
| <input type="checkbox"/> | <input type="checkbox"/> | Education provided by 24/7 College establishment                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Special ethnic and/or religious cultural development/education (please give details) |
| <input type="checkbox"/> | <input type="checkbox"/> | Teaching for English as a second language  |
| <input type="checkbox"/> | <input type="checkbox"/> | Independence/Outreach service for support of children/young person after discharge   |
| <input type="checkbox"/> | <input type="checkbox"/> | Preparation for fostering  |
| <input type="checkbox"/> | <input type="checkbox"/> | Preparation for adoption   |
| <input type="checkbox"/> | <input type="checkbox"/> | Physiotherapy  |
| <input type="checkbox"/> | <input type="checkbox"/> | Occupational Therapy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech Therapy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Training for children/young people with learning difficulties                 |

**Other specialist service (if so please state below:**

Name of Young Person:	
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Does the young person you wish to place with 24/7 Residential Care Limited have any of the following characteristics?

PLEASE TICK ONE BOX

No Yes

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Require special diet for reasons of health, religion or culture |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a baby   |
| <input type="checkbox"/> | <input type="checkbox"/> | Speaks little or no English                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Epileptic-Grand Mal   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthmatic   |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech Impaired   |
| <input type="checkbox"/> | <input type="checkbox"/> | Moderate Learning Difficulties                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Autistic Mild   |
| <input type="checkbox"/> | <input type="checkbox"/> | Autistic Severe   |

Does the young person you wish to place with 24/7 Residential Care Limited have recent or current (within the past 12 months) history of any of the following experiences or behaviour?

No Yes Yes  
Recent Current

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders (anorexia/bulimia)                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enuresis or urine incontinence                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Encopresis or faeces incontinence                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Victim of sexual abuse by females                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or persistent glue/solvent abuse                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or soft drug abuse (please state drug if known)_____  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Absconding   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exclusion from day school                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive verbal abuse towards support workers/or other carers |
|                          |                          |                          | Other (please specify below:)                                  |

Name of Young Person:	
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**MEDICAL**

Please tick box for the primary disability and give additional information as needed:

- Cerebral Palsy
- Epilepsy
  
- Hearing Impairment
- Speech and Language disabilities
- Autism
- Learning difficulties – moderate
- Learning difficulties – severe
- Other
- A.D.H.D
- A.D.D

	Previous	Recent	Current	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Victim of sexual abuse by male
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Victim of sexual abuse by female
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Victim of physical abuse by male
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Victim of physical abuse by female
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Trauma (including victims of war/torture)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Suicidal threats or attempts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Self injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Bullying of others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Fire Setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Stealing from family/peer group
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Burglary/theft from member of public/business or other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Physical violence towards male young person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Physical violence towards female young person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Physical violence towards male support worker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Physical violence towards female support worker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Use of weapons in physical violence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Throwing glass at member of staff
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Destruction of property
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sexual abuse by other male young person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sexual abuse by other female young person
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Prostitution
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sexual advances towards support worker

Name of Young Person:	
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The information contained herein is received in good confidence and faith. Responsibility however will be placed upon Local Authority or other completing this form and / or supplying additional information for any errors, omissions or inaccuracies in the information or for any loss or damage which may result from reliance being placed upon it.

**Please detail any additional information you feel relevant below:**

**Signed**

**Name**

**Position**

**Date**