**Via – Elev8 Health & Wellbeing Service Referral Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the parent/carer aware of/in agreement with the referral?  | Yes |  | No |  |
| Is the young person aware of/in agreement with the referral?  | Yes |  | No |  |
| If no, please explain why in ‘Reason for referral’ below |
|  |  |
| **Young Person’s Details** | **Referrer’s Details** |
| YP Name |  | Date of referral |  |
| Age |  | DOB |  | Name of referrer |  |
| Address |  | Referrer’s agency |  |
| Referrer’s contact details: |  |
| Postcode |  |
| Accomodation Status (eg: Living with relative, semi-independent, independent etc) |  | Is YP open to social care?(please provide further details, eg: current plan, social workers details) |  |
| Telephone |  | Child protection concerns, inc. abusive, violent relationships?  | Yes |  | No |  |
| Mobile |  | If yes, please give details (inc. lead agency/name of worker): |
| Email |  |
| Preferred method of contact |  |
| Consent to contact: (please tick) | Address: Telephone:Mobile:Email: |
| Gender  |   | Ethnicity |  | Would this young person pose any significant risk to staff or others?  | Yes |  | No |  |
| Nationality |  | If yes, please give details: |
| Language spoken |  |
| Attending school?  | Yes |  | No |  |  |
| If yes, name of school? |  | Is there a CAF? | Yes |  | No |  |
| NHS No. |  |
| **Other agencies involved** | **Name and address of GP** |
| Name/agency: | Tel number: |  |
|  |  |
|  |  |
|  |  |
| **Reason for referral** |
| *Concerns, drug use, motivation, any risk factors, mental health issues, emotional difficulties…* |

|  |
| --- |
| **Risk Screen** |
| Pregnancy  |   | A parent |   | Injecting Drug Use  |   |
| High risk sexual behaviour  |   | Involved in gang activity |   | Suicide Risk  |   |
| Mental Health Concerns |   | Vulnerable to abuse or exploitation |   | Involvement with the CJS |   |
| Homelessness |   | Involved with social care services |   |  Other (please specify below) |  |
| Please provide further details:      |

**Please fill in and return via email:**

* **Email:** brentyp@viaorg.uk

**For any queries, please contact us:**

* **Tel:** 0300 3034547
* **Email:** brentyp@viaorg.uk

**For Via use only**

Date referral received: ………………………………………………………………

Referral received by: …………………………………………………………….

Nebula No.: ……………………………………………………………………………….