COMPREHENSIVE REFERRAL FORM

PLEASE COMPLETE FORM AND RETURN TO referrals@istyss.com

DATE OF REFERRAL: ______________________________

We provide homes that actively nurtures and cares for young people, affording them the same rights and opportunities as enjoyed by those not "living in care", to enable them to reach their full potential and grow to become responsible adults.

Has funding for this placement been agreed?

If YES, please provide name of Commissioning Manager……………………………………..

DETAILS OF REFERRING AGENCY

NAME OF LOCAL AUTHORITY:	
ADDRESS OF LOCAL AUTHORITY:	
TELEPHONE NUMBER OF LOCAL AUTHORITY:	
NAME/CONTACT DETAILS OF SOCIAL WORKER:	
NAME OF SOCIAL WORKER'S TEAM:	
TEAM'S CONTACT DETAILS:	
NAME OF COMMISSIONER /PLACEMENT OFFICER:	

DETAILS OF CHILD/YOUNG PERSON

NAME:	
DATE OF BIRTH:	
GENDER:	
RELIGION:	
ETHNICITY/CULTURE:	
LANGUAGE:	
LEGAL STATUS/REVIEW DATES:	
CHILD'S CURRENT ADDRESS:	
NAME OF PERSON WITH PARENTAL RESPONSIBILITY FOR YOUNG PERSON?	
CONTACT DETAILS:	

FAMILY DETAILS

MOTHER	ADDRESS
TELEPHONE	
CONTACT ARRANGEMENTS	
FATHER	ADDRESS
TELEPHONE	
CONTACT ARRANGEMENTS	
SIBLINGS	ADDRESS
TELEPHONE	
CONTACT ARRANGEMENTS	

ANY OTHER FAMILY MEMBERS	ADDRESS
TELEPHONE	
CONTACT ARRANGEMENTS	

ANY OTHER FAMILY MEMBERS	ADDRESS
TELEPHONE	
CONTACT ARRANGEMENTS	

PLEASE IDENTIFY THE CHILD/YOUNG PERSON'S NEEDS AND RISKS

(THIS SECTION NEEDS TO BE COMPLETED)

0 = Shows no sign of this risk
1 = Rarely shows signs of this risk
2 = Sometimes shows signs of this risk
3 = Regularly shows signs of this risk

PRESENTING BEHAVIOUR	YES/NO	LEVEL OF RISK
Suicide threats or attempts		
Self-harming		
Medical Conditions which may affect behaviour		
High risk medical condition (e.g. Asthma)		
Eating disorders		
History of violence towards children (including triggers)		
History of violence towards adults (including triggers)		
History of violence towards animals		
Has the child/YP had any martial arts training?		

Sexual relationships with others		
Sexualised behaviour		
Fire setting		
Bullying others		
Destruction of property		
Drugs, solvent and/or alcohol use/misuse		
Criminal behaviour/forensic history		
History of absconding		
Discriminatory behaviour		
Other identified risks and need for supervision Please Mention if Yes:		

EDUCATION

DOES THE YOUNG PEROSN ATTEND SCHOOL OR EDUCATION PROVIDER?	YES	NO
IF YES - NAME OF SCHOOL OR EDUCATION PROVIDER:	CONTACT NAME:	
	ADDRESS:	
	TELEPHONE NUMBER:	
IF NO - DETAILS OF LOCAL AUTHORITY'S EDUCATIONAL PLAN FOR YOUNG PERSON:	PLAN:	
DOES THE YOUNG PERSON HAVE AN EHCP?	YES	NO

IF YES, HAVE YOU ATTACHED A COPY?	YES NO

Please include recent, relevant assessments conducted by any professionals listed above.

HEALTH

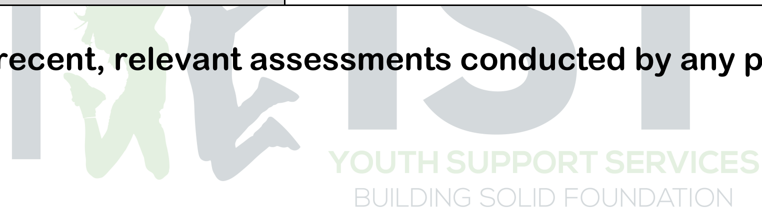
DOES THE YOUNG PERSON REQUIRE MEDICATION OR HAVE ANY MEDICAL NEEDS?	YES NO
IF YES – IDENTIFY THE NAME AND CONTACT DETAILS OF ANY AGENCIES INVOLVED:	
PLEASE PROVIDE THE DETAILS OF ANY UPCOMING MEDICAL REVIEWS:	
DOES THE YOUNG PERSON HAVE ANY DIETARY NEEDS?	YES NO
IF YES - PLEASE GIVE DETAILS:	
DOES THE YOUNG PERSON HAVE A HISTORY OF SUBSTANCE USE/MISUSE?	YES NO
IF YES – IDENTIFY THE NAME AND CONTACT DETAILS OF ANY AGENCIES INVOLVED:	
DOES THE Y/P PRESENT WITH SOCIAL AND/OR EMOTIONAL DIFFICULTIES?	YES NO
IF YES -– IDENTIFY THE NAME AND CONTACT DETAILS OF ANY AGENCIES INVOLVED:	
DETAILS OF ANY OTHER PRESENTING ISSUES:	

Please include recent, relevant assessments conducted by any professionals listed above.

MEDICAL

NAME OF G. P	ADDRESS
TELEPHONE	
HOSPITAL INFORMATION IF APPLICABLE	
NAMES OF DOCTORS/CONSULTANTS ETC	ADDRESS
TELEPHONE	

Please include recent, relevant assessments conducted by any professionals listed above.



OTHER AGENCIES WORKING WITH CHILD/YOUNG PERSON OR WITH THEIR FAMILY

(e.g. Play Therapist, Independent Visitor)

NAME AND ADDRESS	TEL
NAME AND ADDRESS	TEL

Please include recent, relevant assessments conducted by any professionals listed above.

WHAT IS THE CHILD/YOUNG PERSON'S WISHES/FEELINGS ABOUT THE PLACEMENT REQUESTED?

(THIS SECTION NEEDS TO BE COMPLETED)

WHAT ARE THE FAMILY'S WISHES/FEELINGS ABOUT THE PLACEMENT REQUESTED?

(THIS SECTION NEEDS TO BE COMPLETED)

RELIGIOUS / CULTURAL/LANGUAGE NEEDS

REASON FOR ACCOMMODATION REQUEST

BRIEF OUTLINE OF LOCAL AUTHORITY'S PLAN FOR YOUNG PERSON

ESTIMATED LENGTH OF STAY

PLEASE INCLUDE RELEVANT ADDITIONAL REPORTS WITH THIS REFERRAL

	Sent by L.A	Received by IST Youth Support Services (date)	On child's file (date)
Initial Assessment			
Core Assessment			
LAC Documents-Essential 1 & 2			
-Placement Plan 1 & 2			
- Care Plan			
Recent Review (s)			
Psychiatric/Psychological			
Case Conference Reports			
PEP			
EHCP			
School/Educational Reports			
Assessment and Action Records			
YOT Report			
Child Protection Information			

PRE-PLACEMENT PLANNING MEETING

The following will be discussed/completed:

1. Placement Plan (complete at meeting)
2. Confirmation of length of placement
3. Care Plan for day-to-day arrangement at IST Youth Support Services

   - Health
   - Education
   - Identity
   - Social/Leisure
   - Self-care skills
   - Emotional/Behavioural development
   - Contact with family

4. Identify any Child Protection issues/plans/next conference
5. Risk Assessment (draw up at meeting)
6. Any special arrangements
7. Any other issues
8. Fix date of first review (no later than 4 weeks after admission)