The information on this form will be used to help us to offer support that meets the young person’s and family's needs and ensure that we keep them and their allocated worker safe. It will be stored securely on The Children’s Society’s systems in line with the General Data Protection Act.

**Once complete please submit referrals to**

icyc@childrenssociety.org.uk

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| **YOUNG PERSONS DETAILS:** |
| **Name:** |  |
| **Date of birth**  |  |
| **Address** |  |
| **Gender** |  |
| **Ethnicity** |  |
| **Religion** |  |
| **Contact number for young person (if over 13)** |  |
| **Name, contact number and email address of Guardian(s):** |  |
| **DOB of Guardian(s)** |  |
| **LAC / CIN / CP / EARLY HELP / NONE** |  |
| **Has this family/young person ever worked with ICYC or Kidstime previously** |  |
| **Does this YP consent to being referred to Kidstime?** |  |
| **Does their parent consent to the referral?** |  |
| **Does this YP have any special educational needs or disabilities?** |  |
| **Has this family accessed Kidstime previously?** |  |

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| **BACKGROUND HISTORY AND REASON FOR REFERRAL** |
| **Details of Mental Illness and current impact on parent/child and family e.g. impact on parenting, worry from the child** |  |
| **Is the young person aware that their parent/carer has a mental illness** |  |
| **Please tell us why you are referring this young person and family to Kidstime and what you hope they will gain from working with us?** |  |
| **Is the family aware that Kidstime is a multi-family group where discussions surrounding their mental health will be explored** |  |
| **Any other information which may be useful to us in supporting the parent/child/ family within the group?** |  |
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| **FAMILY COMPOSITION:** |
| **Name** | **Relationship to young carer?** | **D.O.B** | **Ethnicity** | **Disability?****(Diagnosis of cared-for must be included)** | **Contact Details:** |
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| **DETAILS OF REFERRER:** |
| **Name & Role** |  |
| **Contact Number** |  |
| **Email** |  |
| **Date of Referral** |  |

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| **OTHER KEY PROFESSIONALS INVOLVED IN SUPPORTING THE YOUNG PERSON OR FAMILY: School, GP, Mental Health Professional, CAMHS** |
| **Name & Role** |  |
| **Contact Number** |  |
| **Email** |  |
|  |
| **Name & Role** |  |
| **Contact Number** |  |
| **Email** |  |
|  |
| **Name & Role** |  |
| **Contact Number** |  |
| **Email** |  |
|  |
| **Name & Role** |  |
| **Contact Number** |  |
| **Email** |  |