

Email completed referrals to [Ydtherapeutic.services@yellowdoor.cjsm.net](mailto:Ydtherapeutic.services@yellowdoor.cjsm.net)

**Disclaimer:** Please be aware that your referral has been logged but will not be active until we have received this completed form. All referrals are reviewed and considerations are made as to whether we are the appropriate service.

DATE:

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| **Yellow Door Young People’s Service Referral (*please see Section 9 for referral guidance prior to completing this referral*)** |

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| **SECTION 1 – YOUNG PERSON DETAILS** | | | | | | | |
| **Forename** |  | | | | | **Surname** |  |
| **Also known as** |  | | | | | **Date of Birth** |  |
| **Gender** |  | | | | |
| **Address at which the child/young person is currently living** |  | | | | | | **Landline / home telephone number** |
| **Child/young person mobile number** |  | | | | | **Parent’s/Carer’s mobile number** |  |
| **Is the Child / Young Person: (tick all that apply) –** | | | | | | | |
| □ Living with parents | □ Living with relatives | | | | | | □ Other (please state) |
| □ Looked After Child | □ Subject to a Child Protection Plan | | | | | | □ Adopted |
| First language: | | Interpreter required? □ Yes □ No  If yes, which language? | | | | | |
| Does the child/young person consider themselves to be transgender?  □ Yes □ No | | Sexual orientation:  □ Heterosexual □ Gay  □ Lesbian □ Bisexual □ Prefer not to say | | | | | |
| Does the child / young person have a disability?  □ Yes □ No  If Yes, Please specify: | Does the child / young person have a  Visual impairment □ Yes □ No  Hearing impairment □ Yes □ No | | | | | | Is the child / young person a Young Carer?  □ Yes □ No |
| **Name of GP** |  | | | | | **GP surgery name** |  |
| GP surgery telephone number and email address |  | | | | | GP surgery address: |  |
| **Ethnicity** | □ White British | | □ Irish | | | | □ Gypsy or Irish Traveller |
| □ White and Black Caribbean | | □ White and Black African | | | | □ White and Asian |
| □ Indian | □ Pakistani | | □ Chinese | | | | □ Bangladeshi |
| □ Any other Asian background | □ African | | □ Caribbean | | | | □ Other Black/Caribbean/African Background |
| □ Arab | □ Any other ethnic group – please state | | | | | |  |
|  | □ Any other mixed / multiple ethnic background – please state | | | | | |  |
| **Religion** | □ Agnostic □ Atheist □ Baha’I □ Buddhist □ Chinese (Taoist / Confucian)  □ Christian □ Hindu □ Humanist □ Japanese (Shinto) □ Jewish □ Jainism  □ Muslim □ Pagan □ Rastafarian □ Sikh □ Spiritualist  □ Do not wish to disclose □ Other | | | | | | |
| **SECTION 2 – PARENT/CARER DETAILS** | | | | | | | |
| **Who holds parental responsibility for the child /young person?** | | | | | | | |
| Forename |  | | Surname | | | |  |
| Relationship |  | | Telephone number: | | | |  |
| Address |  | | | | | | |
| **Is there any history of parental mental health difficulties and/or history of substance misuse?** □ Yes □ No | | | | | | | |
| If yes, please provide details: | | | | | | | |
| **Is there any history of domestic violence within the family?** □ Yes □ No | | | | | | | |
| If yes, please provide details: | | | | | | | |
| **Are there any adult services currently involved?** □ Yes □ No | | | | | | | |
| If yes, please provide details: | | | | | | | |
| **SECTION 3 – CHILDREN’S SERVICES** | | | | | | | |
| Name of Allocated Social Worker or Family Support Worker |  | | | | | | |
| Children’s Services Team |  | | | | | | |
| Address |  | | | | | | |
| Telephone |  | | | | | | |
| **SECTION 4 - EDUCATION** | | | | | | | |
| Name of School/College: | | | | | School/College address and telephone number: | | |
| Home school / Tutor | | | | | Please give details: | | |
| **SECTION 5 – PRESENTING ISSUES, RISK AND CONCERNS** | | | | | | | |
| Please state any mental health difficulties, onset, frequency and duration, current presenting risk, details of any self harming behaviours, suicidal ideation/intent, interventions tried, impact on child and family, impact on education, and any relevant medical history: | | | | | | | |
| **What services have been accessed already?**  **Is this support ongoing?** | | | | | | | |
| **Is the young person on any current medication?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **Are there any concerns relating to substance misuse?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **Are there any concerns relating to food/weight/suspected eating disorder?** □ Yes □ No If Yes, please provide details: | | | | | | | |
| **SECTION 6 - Reasons for Referral** | | | | | | | |
| **Sexual abuse/violence** □ Yes □ No If Yes, please provide details:  **Domestic violence**□ Yes □ No If Yes, please provide details: | | | | | | | |
| **What is you expectation of what support at Yellow Door might help with** | | | | | | | |
| **SECTION 7 – REFERRER DETAILS** | | | | | | | |
| Name |  | | | Job Title/Profession: | | |  |
| Address | | | | | | | |
| Post Code: | | | | Telephone: | | |  |
| Date of Referral |  | | | Email address | | |  |
| Are you still offering Child/Young person a service □ Yes □ No    If yes what is being offered?  If no what are the reasons for not offering a service? | | | | | | | |
| **SECTION 8 - REFERRAL CONSENT** | | | | | | | **If no, please give reason** |
| Does the Parent/Carer know about the referral? | | | Yes | | | No |  |
| Does the Parent/Carer consent to the referral? | | | Yes | | | No |  |
| Does the Child/Young Person know about the referral? | | | Yes | | | No |  |
| Does the Child/Young Person consent to the referral? | | | Yes | | | No |  |
| Does the Child/Young Person want Yellow Door support | | | Yes | | | No |  |
| Who should be our main contact  (please delete as appropriate) | | | Young person | | | Parent/Carer | Other  Details: |
| Preferred method of contact | | | Phone | | | Email | Post |
| **For referral criteria, please see overleaf:** | | | | | | | |
| **SECTION 9 - REFERRAL GUIDANCE** | | | | | | | |
| **Guidance for Referrer's - Yellow Door Young Person’s Therapeutic Services**  YD Therapeutic services offer a range of group interventions and some time limited 1-1 work with Young People who have witnessed and / or experienced Domestic or Sexual Abuse (DSA). We also offer Family Therapies as well as Prevention, Advocacy, Criminal Justice Support and Diversity and Inclusion services to those who are vulnerable to or impacted by DSA (please see website for further details).  Prior to making a referral to our Young People’s Therapeutic Service please consider:   * Whether the Young Person has the emotional resilience to engage in a structured therapeutic intervention. * Whether the Young Person’s circumstances are sufficiently stable to support regular and meaningful attendance as well as positive therapeutic outcomes. * Whether the Young Person has Mental Health needs beyond the mild to moderate range that we are able to work with. Please bear in mind that **YD is not resourced to manage significant or chronic risks** such as those relating to ongoing suicidal ideation or to self-injurious behaviours that are severe and/or repeated.   At the point of referral, we can provide estimated waiting times but please be aware that each of our therapy services operate with a waiting list system. Where YD has started therapeutic interventions and a risk profile escalates and/or complexity becomes apparent such that we consider YD interventions to be contra-indicated, we will work with appropriate services to plan transition.  **Yellow Door Therapeutic Interventions for Young People**  **1:1 Counselling**  Talking therapy that allows children and young to discuss any experiences or difficult feelings. They might have specific experiences or events they would like to talk to someone about or work through, or the space can be used to explore thoughts and feelings in more depth.  **Art Therapy**  We are able to offer art therapy to children and young people. This can be a fun and creative way to  express any difficulties through a range of different art materials, techniques and activities. Art therapy can work particularly well with younger people, who may struggle with traditional talking therapies that rely on verbal descriptions of events, feelings, hopes and fears.  ​  **Creative Group**  The purpose of the group is to offer young people who have experienced abuse within family relationship a safe, confidential space to reflect and share any thoughts around issues or anything that they might be struggling with or finding hard to manage. Facilitators use guided creative activities as a way to support the group development and help build peer relationships. This will lead to more self directed activities and begin to look at what they want to achieve and explore in the group. The facilitators will support the group to explore chosen themes and look at the difficulties they are all experiencing together.  **Trauma Informed Psycho-Education Group**  This group has been developed to support young people aged 15 - 19 who have experienced sexual assault, rape, or abuse within a relationship. It uses both creative interventions and psycho-educational techniques to explore topics like trauma and relationships, supporting young people to understand more about emotional and psychological reactions to negative and traumatic experiences.  **Bright Stars**  This group offers a therapeutic space for young people to explore their thoughts and feelings around their experiences of domestic abuse. The group welcomes any young person who has witnessed or directly suffered domestic violence – either at home within the family, or within their own personal relationships.   It works to explore topics in a thoughtful but creative and fun way by including group discussions, games and craft activities. | | | | | | | |
| **FOR OFFICE USE ONLY** | | | | | | | |
| To be discussed with coordinator □ Yes □ No  To be taken to screening meeting □ Yes □ No  Further information required □ Yes □ No  Request for Info sent□ Yes □ No  **Not appropriate referral for therapeutic services**  Reason…………………………………………………Signposted to………………………………………………………Date……………………  Client notified………………………………….Date………………………………………..  **Additional Internal Support Signposting – requested or suitable for:**  **TFT ISVA DIA DAT**  **Please state if internal support is being offered instead of/as well as Therapuetic Services**  Referral made □ Yes □ No  Date………………………  **Appropriate referral for therapeutic services □ Yes □ No**  Manager checked …………………………………………………….. Date………………………………………………………………………………..  **Circle recommended therapeutic Services Intervention :**  FT FS 1:1 Then & Now ECS Safer Relationships Psychoeducation group  Creative Arts Bright Stars Art Journaling Telephone Support Email Support  **Added to waiting list □ Yes □ No**  **Waiting list email sent Date: ………………………………………………………………….** | | | | | | | |