

Email completed referrals to 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 Family Therapy/Family Support Referral (*please see Section 9 for referral guidance prior to completing this referral*)** |

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| **SECTION 1 – LEAD CLIENT DETAILS** |
| **Forename** |  | **Surname** |  |
| **Also known as** |  | **Date of Birth** |  |
| **Gender** |  |
| **Address**  |  | **Landline / home telephone number****Email Address:** |
| **Mobile number** |  |  |
| First language:  | Interpreter required? □ Yes □ No If yes, which language? |
| Do any family members consider themselves to be transgender?□ Yes □ No | Sexual orientation of lead referrer:□ Heterosexual □ Gay □ Lesbian □ Bisexual □ Prefer not to say |
| Do any family members have a disability?□ Yes □ NoIf Yes, Please specify: | Do any family members have a:Visual impairment □ Yes □ No Hearing impairment □ Yes □ No | Are the child(ren) / young persons a Young Carer?□ Yes □ No |
| **Name of GP** |  | **GP surgery name** |  |
| GP surgery telephone number and email address |  | GP surgery address: |  |
| **Ethnicity (Lead Client)** | □ 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 (Lead Client)** | □ 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 children /young persons?** |
| Forename |  | Surname |  |
| Relationship |  | Telephone number: |  |
| Address |  |
| **Do any family members have a history of mental health difficulties and/or history of substance misuse?** □ Yes □ No  |
| If yes, please provide details:  |
| **Are there any adult services currently involved?** □ Yes □ No  |
| If yes, please provide details:

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| **SECTION 3 – FAMILY INFORMATION** |
| **Are the Children / Young Persons: (tick all that apply) –** |
| □ Living with parents | □ Living with relatives | □ Other (please state) |
| □ Looked After Child | □ Subject to a Child Protection Plan | □ Adopted |

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| Family Names  | Age / DOB | Gender: |  Notes  |
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**Additional Information for CYP:**School/college/ nursery:Any other relevant information regarding family or young people: |
| **SECTION 4 – CHILDREN’S SERVICES** |
| Name of Allocated Social Worker or Family Support Worker |  |
| Children’s Services Team |  |
| Address |  |
| Telephone  |  |
| **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?** |
| **Are any family members 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 any family members 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 the family 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 | OtherDetails: |
| Preferred method of contact | Phone | Email | Post |
| **For referral criteria, please see overleaf:** |
| **SECTION 9 - REFERRAL GUIDANCE** |
| **Guidance for Referrer's - Yellow Door Family Therapy Services** YD Therapeutic services offer short term Family Therapy to those who are vulnerable to or impacted by DSA (please see website for further details).In our experience the families who are most likely to benefit from our family therapy services are:Those free from ongoing family law proceedings and those who are not experiencing high risk related to current domestic violence.Prior to making a referral to our Family Therapy Services please consider:* Whether the family members have the emotional resilience to engage in a structured therapeutic intervention.
* Whether the family’s circumstances are sufficiently stable to support regular and meaningful attendance as well as positive therapeutic outcomes.
* Whether the family members have 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. |

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| **FOR OFFICE USE ONLY** |
| To be discussed with coordinator □ Yes □ NoTo be taken to screening meeting □ Yes □ NoFurther information required □ Yes □ NoRequest 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 DATPlease state if internal support is being offered instead of/as well as Therapuetic Services **Referral made** □ Yes □ NoDate……………………… **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: ………………………………………………………………….** |