**Children and Young Persons Wellbeing Practitioner Referral Form**

Once complete, please send via **Email** to [**wellbeing@ymcaexeter.org.uk**](mailto:wellbeing@ymcaexeter.org.uk)**.** This is a secure email and is regularly monitored.

If you have any difficulties with this form or would like to speak to someone about your referral, please contact us on **01392 410530 */*** [**wellbeing@ymcaexeter.org.uk**](mailto:wellbeing@ymcaexeter.org.uk)**.**

**If the child or young person is at risk of harm to themselves or others, please contact their GP or professional involved in their care to discuss a safety plan as we are not able to provide emergency care.**

**All information given will be treated as strictly confidential.**

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| **REFERRER DETAILS** | |
| **Referring agency:** | Click or tap here to enter text. |
| **Date of referral:** | Click or tap to enter a date. |
| **Name and job title of referring worker:** | Click or tap here to enter text. |
| **Phone number:** | Click or tap here to enter text. |
| **Email address:** | Click or tap here to enter text. |

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| **PARENT/CAREGIVER(S) DETAILS (IF APPROPRIATE)** | |
| **Full name:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |
| **Home number:** | Click or tap here to enter text. |
| **Mobile number:** | Click or tap here to enter text. |
| **Do you give us permission to leave a voicemail?** | Yes  No |
| **Any other relevant information:** | Click or tap here to enter text. |

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| **CHILD OR YOUNG PERSON’S DETAILS** | |
| **First name:** | Click or tap here to enter text. |
| **Last name:** | Click or tap here to enter text. |
| **Date of birth:** | Click or tap to enter a date. |
| **Contact number:** | Click or tap to enter a date. |
| **Contact email:** | Click or tap to enter a date. |
| **Gender:** | Male  Female  Prefer not to say |
| **Does this child or young person have a disability?** | Yes  No  Prefer not to say  *If yes, please specify:* Click or tap here to enter text. |
| **Does this child or young person require constant supervision or care due to a disability?** | Yes  No |
| **Is this child or young person a Young Carer?** | Yes  No  *If yes, please specify who are they a Young Carer for?:* Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Postcode:** | Click or tap here to enter text. |
| **Accommodation Status:** *(Please tick the relevant option)* | Parent or carer owns/rents the house  Temporary accommodation  Sofa surfer  Supported lodgings  *If an alternative answer, please specify:* Click or tap here to enter text. |
| **Ethnicity:** *(Please tick)* | ***Mixed:***White and Back Caribbean  White and Black African  White and Asian  Other  ***White:***White British  White Irish  White other  ***Asian or Asian British:***Indian  Pakistani  Bangladeshi  Other  ***Black or Black British:***Caribbean  African  Other  ***Other ethnic groups*** *(Please specify):*Click or tap here to enter text.  ***Prefer not to say*** |
| **Long Term Condition Status:** *(Please tick the relevant option)* | Asthma  Heart Failure  Cancer  Epilepsy  Chronic pain  Diabetes  Dementia  Medically Unexplained Conditions  No Long Term Health Conditions |
| **Child Protection Plan:** *(Please tick the relevant option)* | Has never been subject to a Child Protection Plan  Has previously been subject to a Child Protection Plan  Is currently subject to a Child Protection Plan |
| **Is this child or young person a Looked After Child?** | Yes  No  Prefer not to say |
| **Who is this child or young person’s Education provider?** *( E.g. School name, College name, Apprenticeship facility)* | Click or tap here to enter text. |
| **GP Practice (if known):** | Click or tap here to enter text. |
| **Child or young person’s NHS number:** | Click or tap to enter a date. |
| **Who is the child or young person’s registered GP?** | Click or tap here to enter text. |
| **Do you consent for this child or young person’s data to be kept on confidentially on YMCA Exeter’s record?** | Yes  No |

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| **REASON FOR REFERRAL** |
| *Please give as much detail as possible about presenting difficulties as well as; duration, main symptoms, impact on day to day life, additional difficulties.*  Click or tap here to enter text. |