

Office Use Only

Inform ref:



YAC Mind the Gap - Referral Form

- Please complete this form with the young person who is being referred present.
- Please complete and return this form to yaccrawley@ymcadlg.org.
- We aim to respond to all referrals within 14 days.
- For any queries please contact the Mind the Gap team at yaccrawley@ymcadlg.org.

Referrer's Details

Referrer's Name	<input type="text"/>	Today's Date	<input type="text"/>
Referring Service	<input type="text"/>		
Phone Number	<input type="text"/>	Email	<input type="text"/>
Referrer's role in relation to young person	<input type="text"/>		

Young Person's Details

Full Name	<input type="text"/>	Known As	<input type="text"/>
D.o.B.	<input type="text"/>	Age	<input type="text"/>
		Pronouns	<input type="text"/>
Address	<input type="text"/>		
Postcode	<input type="text"/>	Email	<input type="text"/>
Mobile	<input type="text"/>	Home Phone	<input type="text"/>
Preferred Contact Method:	Text <input type="checkbox"/>	Call <input type="checkbox"/>	Email <input type="checkbox"/>
Can we leave a voicemail? Y/N	<input type="checkbox"/>	Can we contact your parent/guardian? Y/N	<input type="checkbox"/>
Ethnicity	<input type="text"/>		

Religion (please tick one)

Buddhist	<input type="checkbox"/>	Christian	<input type="checkbox"/>	Hindu	<input type="checkbox"/>	Jewish	<input type="checkbox"/>	Muslim	<input type="checkbox"/>	No Religion	<input type="checkbox"/>
Sikh	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other (please specify)	<input type="text"/>						

Gender (please tick one)

Female	<input type="checkbox"/>	Male	<input type="checkbox"/>	Non-binary	<input type="checkbox"/>	Trans F	<input type="checkbox"/>	Trans M	<input type="checkbox"/>
Unsure	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other (please specify)	<input type="text"/>				

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Sexual Orientation (please tick one)

Bisexual Gay Heterosexual Lesbian Queer
Unsure Prefer not to say Other (please specify)

Parent/Guardian Contact Details

Full Name
Relationship Phone Number
Email

Emergency Contact (if left blank we will use parent/guardian details)

Full Name
Relationship Phone Number

GP Contact Details

Surgery Name GP Name
Surgery Postcode Phone Number

School/College Contact Details (if applicable)

School/College Name
Staff Member Phone No.
Email

Risk Screen (please tick all that apply)

Risk Area	In the last 6 months	More than 6 months ago	N/A
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence or aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe self-neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Any more information about the above risks or any other safeguarding concerns?

If you have any diagnoses or are taking any medications, please list them here:

If you have used or are using any other support services (such as Mind the Gap, YES, Dialogue or Sussex Oakleaf) please list their name(s) and when you used them here:

Referral Details

Current issues including family, school, friendships:

Impact on young person:

How would you like the Mind the Gap team help?

Please tick below which session type(s) that the young person would be happy to attend:

One to one Groups

Please complete the Information Sharing Agreement on the next page and return this form to yaccrawley@ymcadlg.org

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Information Sharing Agreement

In our work with you we may need to share some of your information with others – in which case, we will keep you informed. We may need to do this so you can get the right support from us or external agencies, which also means that you won't have to repeat this information to each worker you meet. Please also be aware that sometimes we have a duty to share information, even without your consent, if we are concerned that someone is at risk of significant harm or if a serious crime has occurred. Please see the Information Sharing Leaflet and Privacy Notice attached for further details.

I authorise any third party (including the police and medical representatives) to share any records or information they hold on me to YMCA DownsLink Group.

Please tick ONE of the following:

I consent to information being shared with other people and agencies if my worker thinks it will benefit me.

I consent to information being shared but do not want information being shared with these specific workers/people (e.g. family members) / agencies (please write below):

I do not consent to any information being shared with other people or agencies. **Please note, if you tick this box, we may be unable to work with you; talk to a worker to find out why.**

Young Person Signature OR Signature of carer/parent/guardian - if appropriate – we will only seek their consent if the young person concerned is under the age of 13, or if you have found it difficult to understand the information sharing rules, and if it is safe for us to do so.

Sign

Date