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| **BeLeave Project Referral Form** |
| *- Focus on prevention of girls (aged 8-18) becoming involved with or impacted by child criminal exploitation.*  *- 12 session intervention; direct one-to-one with young person, and family intervention.*  *- Community awareness raising* |

**Referral arrival date (office use only):** Click here to enter a date.

The information provided in this form will be kept confidentially and securely within Spurgeons and shared as appropriately between Spurgeon’s service personnel. *Forms that are incomplete or that do not have sufficient information will delay the process of allocation whilst additional information is being gathered.*

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| **Criteria** |
| **Inclusion criteria** (*please tick as appropriate)***:**  ***One or more of the following are required:***  Primary presenting issues may revolve around; (anti-social behaviour, criminal activity etc.)  Girls at risk of or involved in gang related activities.  Girls who are exploited by gangs through a third party; e.g. family member, friend.  ***In addition please select two or more of the following*:**  Home residence is within Birmingham regions  Poor school attendance; e.g. below 90% attendance recorded within the last month  Displaying violent or risky behaviour; where there is a potential to harm self or others  Associates with older pro criminal peers.  Incidents of going missing  Drug/substance misuse |

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| **Referrer Details** | |
| Name: | Contact Number: |
| Address: | |
|  | Postcode: |
| Email Address: | |
| Job Title & Organisation: | |
| Date: Click here to enter a date. | |
| Which referral route is this referral through? Choose an item. | |
| What actions have you taken to access support for the young person/family: | |
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| **Consent** | |
| Date parental consent obtained: | Click here to enter a date. |
| Is the young person aware of this referral being made? | Yes  No |
| What is the young person’s **and** parent’s views regarding this referral (**required\*)**: | |
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| **Young Person Details** | |
| Name: | Date of Birth: |
| Address: | Gender: |
|  | Home Telephone Number: |
| Postcode: | Mobile: |
| Preferred Language: | Ethnic origin: |
| Is an interpreter required? : Yes  No | Religion: |

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| **Additional Needs** | |
| Does the young person have any disabilities/ medical conditions / special educational needs or mental health needs? | Yes  No |
| If Yes, please give details: | |
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| **Parent/carers details** | |
| *Parent/Carer 1* | *Parent/Carer 2* |
| Name: | Name: |
| Address: | Address: |
|  |  |
| Postcode: | Postcode: |
| Contact Number | Contact Number: |
| Ethnic Origin: | Ethnic Origin: |
| Religion: | Religion: |
| Do they have Parental Responsibility/ Guardianship? | Do they have Parental Responsibility / Guardianship? |
| Relationship to young person: | Relationship to young person: |

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| **Other Family Members (including siblings/ grandparents/ carers etc. if significant)** | | |
| Name: | Name: | Name: |
| Date of Birth: | Date of Birth: | Date of Birth: |
| Gender: | Gender: | Gender: |
| Relationship to young person: | Relationship to young person: | Relationship to young person: |
|  |  |  |
| Address: | Address: | Address: |
|  |  |  |
| Postcode: | Postcode: | Postcode: |
| Contact Number: | Contact Number: | Contact Number: |

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| **Family Early Help Assessment (formerly fCAF)** | |
| Do you know if a Family Early Help Assessment has been completed? | Yes  *please attach copies*  No |

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| **Safeguarding / Child Protection** | |
| Social Workers Name: | Contact Number and Email Address: |
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| Is the young person subject to a Child Protection Plan? | Yes  No |
| Is the young person a Looked After Child? | Yes  No |
| Is the young person being support by a Think Family Team? | Yes  No |
| Is the young person subject to any Court Orders? | Yes  No |
| Does the young person have any pending prosecutions? | Yes  No |

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| **Any other agencies/professionals working with the young person or their family** | | | |
| **Agency** | **Contact Name and Role** | **Address** | **Contact Number and**  **E-mail Address** |
| School / College |  |  |  |
| GP |  |  |  |
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| **Referral** |
| **Please explain why you are making this referral, giving detail to each criterion you have selected previously. (***Your information will help us to determine the level of risk and appropriate measures that can be implemented.*  *This information will be shared with the family).*  **Any risks associated with home visits:**  **Please outline what is going well at the moment and some of the family strengths.** |



**Please return this referral form to:**

**Email:**

[**beleaveproject@spurgeons.org**](mailto:beleaveproject@spurgeons.org)

**If you have any questions around completing this form please call:**

**Telephone:**

**0121 638 0876**