Please complete and send to [youcounselling@theyoutrust.org.uk](mailto:youcounselling@theyoutrust.org.uk)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer** | | | | | | | | | |
| **Referring Agency:**  **Worker Name:**  **Contact Details:** | | | | | | | **Date**  **Referred:** | | |
| **Young Person’s Details** | | | | | | | | | |
| First Name: | | | | | | Surname: | | | |
| Also known as: | | | | | | | | | |
| Date of Birth: | | | | | | | | | |
| Address:  Postcode:  **Contact information for young person *(if applicable):***  Telephone:  Email: | | | | | | | | | |
| Can we send information to this address? **Yes  No** | | | | | | | | | |
| Does the individual being referred live with:  Parent(s) RelativesAdopted Carer(s) Looked After | | | | | | | | | |
| Is the young person known to the MET (missing exploited trafficked group)? Yes  No  If trafficking is suspected, has a child NRM (national referral mechanism) form been completed? Yes  No | | | | | | | | | |
| **We request the following information for the purpose of helping our staff use the most respectful language when addressing our clients, in addition to understanding our client demographics better and fulfilling our grant reporting requirements. Please help us achieve this by providing answers to the following questions relating to the individual being referred.**  Gender identity: Choose an item. If ‘other’ please state:  Sexual/Romantic Orientation: Choose an item. If ‘other’ please state:  Ethnic group/background: Choose an item. If ‘other’ please state:  Preferred pronoun: Choose an item. If ‘other’ please state: | | | | | | | | | |
| **Parent/Carer Details** | | | | | | | | | |
| Name of person who holds parental responsibility:  What is their relationship to the individual being referred?  Does the individual being referred live with this person at the same address? Yes  No  If no, what is the address of the person who holds parental responsibility:  Is the parent/carer aware of the referral: Yes  No  Phone number of parent/carer:  Email of parent/carer: | | | | | | | | | |
| **Main Point of Contact Regarding This Referral** | | | | | | | | | |
| **Young Person  Parent/Carer**  Is it safe to call: **Yes  No**  Can we leave a voicemail? **Yes  No**  Can we send a text? **Yes  No**  Can we send an email? **Yes  No**  If **NO** – what is the reason for non-disclosure of this referral? | | | | | | | | | |
| Preferred contact method: Choose an item. | | | | | | | | | |
| **Reason for Referral** | | | | | | | | | |
| **Please indicate the reason for referral and please provide details including any ongoing abuse, e.g. has it been reported to police, details of any ongoing investigation, other agencies involved and what support they are providing.** | | | | | | | | | |
|  | | | | | | | | | |
| **Other Agencies and Education** | | | | | | | | | |
| Name of Agency: | | | | | Name of allocated worker: | | | | |
| Brief overview of support received by this agency: | | | | | | | | | |
| Name of Agency: | | | | | Name of allocated worker: | | | | |
| Brief overview of support received by this agency: | | | | | | | | | |
| Name of School/College: | | | | | Name of key worker/pastoral support: | | | | |
| **Presenting Issues** | | | | | | | | | |
| **Please indicate any other issues** | | | | | | | | | |
| Addiction |  | | Mental Health (please give details) | | | | |  | |
| Anger |  | |  | | | | |  | |
| Anxiety |  | | Neglect | | | | |  | |
| Bereavement / Loss |  | | Physical abuse | | | | |  | |
| Crime |  | | Relationship issues | | | | |  | |
| Depression |  | | Self-Harm | | | | |  | |
| Emotional abuse |  | | Self-Confidence | | | | |  | |
| Family issues |  | | Trauma | | | | |  | |
| Gender / Sexuality |  | | Welfare/Homelessness | | | | |  | |
| Physical Illness / Feeling unwell |  | | Other issues (please give details) | | | | |  | |
| **Medical Details** | | | | | | | | | |
| **We will not disclose to the GP that the individual being referred is having counselling support. Their GP would only be contacted if we believed we needed to take direct action due to a risk to the individual’s health.** | | | | | | | | | |
| Doctor's Name:  Practice:  Address:  Postcode: | | | | | | | | | |
| Has the individual being referred received any mental health diagnosis from their GP or any other mental health professional? **Yes  No** | | | | | | | | | |
| If yes, please give details: | | | | | | | | | |
| Is the individual being referred currently receiving any psychological therapy, counselling or mental health support from any other mental health professional? **Yes  No** | | | | | | | | | |
| If yes, please give details: | | | | | | | | | |
| **Please let us know if the individual being referred has experienced any of the following problems in the last month:** | | | | | | | | | |
| Thoughts of ending their life | |  | | Self-harm | | | |  | |
| Taking steps to end their life | |  | | Harm from another person | | | |  | |
|  | |  | | Harm related to drugs or alcohol | | | |  | |
| Is the individual being referred currently on any medication? **Yes  No** | | | | | | | | | |
| If yes, please give details: | | | | | | | | | |
| **Access to Counselling Sessions** | | | | | | | | |
| In order to support access to sessions we need to seek more information about the individual being referred.  Do they consider themselves to have a disability? Yes  No  If yes please explain:  Would they like us to be aware of any of the following where they may have difficulty or require additional support: Choose an item.  What can we do to support them? | | | | | | | | |

|  |
| --- |
| **What Happens Next** |
| STAR Counselling Centre offer 1:1 and group support for people of all ages who have experienced rape and/or sexual assault. When a referral is received for a young person, our team may contact the referrer to gather further information if required.  **CHILD DIRECTED:** This means we allow the child to focus on their difficulties in a way that best suits their strengths and their ideas of making change. We enable the child to lead the counselling sessions and talk about what they want to talk about.  **SYSTEMS FOCUSED:** This means we may work with people involved in your child’s life to help support positive change. We will also work with you to help make a positive difference in your child’s life.  **STRENGTHS BASED:** This means we use your child’s individual strengths and focus on helping them to make positive change to improve their emotional health and wellbeing. We do this by supporting them to build their own foundations for resilience and problem solving.  **OUTCOME INFORMED:** This means we will ask your child how they feel at the end of each session and show them the progress they are making over the time they are within the service. This supports them to feel like they are achieving their goals and helps shapes the counsellor’s interventions. |
| **Consent** |

|  |  |
| --- | --- |
| Please indicate if you have discussed this referral with the young person (aged 13+) or their parent/carer (12 and under) and received their consent to submit? Yes  No  Please note that the referral **cannot** be accepted without consent of the young person or parent/carer. | |
| **I consent to the information I have provided being processed and stored by STAR Counselling with You (part of The YOU Trust) in order to provide me with counselling services.** | |
| **Signature of young person:** | **Date:** |

|  |  |
| --- | --- |
| **I consent to the information I have provided being processed and stored by the STAR Counselling Centre (part of The YOU Trust) in order to provide the individual referred with counselling services.** | |
| **Signature of parent/carer:** | **Date:** |

A copy of the YOU Trust’s Data Protection Policy can be provided on request.