Arts For Life Project Referral / Self-Referral Form

Please complete applicable information:

REFERRER DETAILS: **Date of Referral:.....**

Name:	Job Title:
Organisation:	Telephone Number:
Mobile Number:	Email Address:
Which **service** are you referring the young person to? (tick all that apply)	**1:2:1 Therapeutic Support** ☐ **Young Person Group Wellbeing Services** ☐ **Adult / Carer Group Wellbeing Services** ☐ **Unsure which support best suits** ☐
Where did you find out about Arts For Life Project?	

CLIENT or SELF-REFERRER DETAILS:

NB: All the information below relates directly to the client receiving support

Name:					Date of Birth:				
Age:					Gender:				
Telephone Number:					Email Address:				
Address with Postcode:									
Ok to contact Young Person directly via phone / text?	YES		NO		Ok to leave a telephone message?	YES		NO	
Ok to contact Young Person directly via messaging services (i.e Whatsapp / iMessage?	YES		NO						
Young Persons Person of Trust? Over 18	Name:				Contact No (mob preferably):				

Name:	Date of Birth:
Alternative / Safe Emergency Contact Details (tel/mobile) ……	
Have their parents/carers been informed of the Referral? YES NO	

STATUS

School (Full Name)……	College (Full Name)……..
Government training	Full-time work
Part-time work	Long term Sick/Disabled
Unemployed	Asylum seeker
Refugee	Other ……

GP Name and Contact Details:

FAMILY COMPOSITION:

Name	DOB and Age	Relationship	Gender	Ethnicity	Religion	Disability
Main Address and Telephone Number if different from Client address:			Other significant Adults not living in the household:			
LIVING WITH: ALONE / PARTNER / CHILDREN / PARENT(S) / CARER(S) / IN CARE / RELATIVE(S) *delete as appropriate						

REASON FOR REFERRAL / BACKGROUND AND INFORMATION: (tick any/all that apply)

- Anxiety/Stress ☐
- Depression/Sadness ☐
- Emotional Resilience Difficulties ☐
(specify).....
- Learning Difficulties ☐
- Behavioural Difficulties ☐
- Lack of Positive Coping Mechanisms ☐
- Trauma ☐
- Abuse ☐
- Self-Harm ☐
- Suicide Ideation ☐
- Sexual Exploitation ☐
- Other ☐

DETAILS & DESCRIPTION OF CONCERN:

GOALS FOR SUPPORT:

CLINICAL / SUPPORT HISTORY:

IS THE YOUNG PERSON TAKING ANY MEDICATION (PLEASE SPECIFY IF KNOWN)? Y/N: IF YES PLEASE GIVE DETAILS
DOES THE YOUNG PERSON HAVE A CLINICAL DIAGNOSIS (PLEASE SPECIFY)? Y/N: IF YES PLEASE GIVE DETAILS
HAS THE YOUNG PERSON MADE ANY SUICIDE ATTEMPTS OR BEEN HOSPITALISED? Y/N: IF YES PLEASE GIVE DETAILS
HAS THE YOUNG PERSON A RECENT HISTORY OF VIOLENCE OR AGGRESSIVE BEHAVIOUR TOWARDS OTHERS? Y/N IF YES PLEASE GIVE DETAILS
HAS THE YOUNG PERSON HAD ANY MEDICAL ILLNESS, INJURY, SUDDEN WEIGHT GAIN/LOSS IN THE LAST 6 MONTHS? IF YES, FOR WHAT?
HAVE THE YOUNG PERSON SEEN YOUR GP IN THE PAST 3 MONTHS? IF SO FOR WHAT?
HAVE THEY DESCRIBED THESE SYMPTOMS TO YOUR GP?
ARE THERE ANY KNOWN ASSOCIATED RISKS E.G DOMESTIC/HONOUR-BASED VIOLENCE? Y/N IF YES PLEASE GIVE DETAILS
IS THE YOUNG PERSON A CLASS A DRUG USER? Y/N IF YES PLEASE GIVE DETAILS
IS THE YOUNG PERSON OR FAMILY MEMBERS ON A CHILD IN NEED PLAN? Y/N IF YES PLEASE GIVE DETAILS.
IS THE YOUNG PERSON OR FAMILY MEMBERS ON A CHILD PROTECTION PLAN? Y/N IF YES PLEASE GIVE DETAILS
HAS THE YOUNG PERSON BEEN A VICTIM OF SEXUAL VIOLENCE? EXPLOITATION? Y/N IF YES PLEASE GIVE DETAILS

The above information is a true and accurate account.

INTERVENTIONS ALREADY COMPLETED							
GP		A & E		HOUSING		CHILDRENS/SOCIAL SERVICES	
DRUG & ALCOHOL		FORCED MARRIAGE UNIT		CAMHS REFERRAL		MENTAL HEALTH TEAM	
PLEASE NAME ANY OTHER ORGANISATIONS OR WORKERS INVOLVED IN THE CLIENTS WELFARE:							
PLEASE LIST ANY FURTHER INFORMATION OR ISSUES RELEVANT TO THIS REFERRAL:							

GDPR

I give permission for photos or other media featuring CYP	YES	NO
I give permission to receive emails from Arts For Life Project	YES	NO
I give permission to receive SMS or other social media messaging platform from Arts For Life Project	YES	NO
*Arts For LIfe Project want everyone who supports us, or who comes to us for support, to feel confident and comfortable with how any personal information you share with us will be looked after or used. This Privacy Policy sets out how we collect, use and store your personal information (*this means any information that identifies or could identify you*).* *The Arts For Life Project Privacy Policy may change so please remember to check back from time to time, this is version 1.1 was last updated on the 25 May 2018. Where we have made any changes to this Privacy Policy, we will make this clear on our website or contact you about any changes.*		

Thank you. Please email to enquiries@artsforlifeproject.org or post to us prior to appointment. Once we received the form we will make contact directly with the young person, if appropriate, or with the referrer within 10 working days in order to discuss their needs further and arrange a first appointment with us UNLESS an appointment has already been arranged.

Please complete the Service Agreement Page: Print, Sign and bring with you to your first visit to AFLP.

Service Agreement

Client Name (Guardian if under 18):	**Registration Date:**
Guardian Name (if CYP under 18):	
CLIENT DOB:	**CLIENT Gender:**
Contact No:	**Email Address:**
Address with Postcode:	

BOUNDARIES:

I understand all relevant fees are due in advance. CANCELLATION: Full fee will be charged if 48hrs notice is not given or for non-arrival. CONFIDENTIALITY: All communication taking place during service is confidential, subject to certain provisions; AFLP staff are not at liberty to withhold information from the police. Your AFLP staff member or AFLP NSP is required to inform the authorities if there is a possibility that you or a member of the public is at risk. It is considered to be confidential if an NHS professional requires information to be able to help you. Parts of your conversation may be referred to during supervision, requirements for registered therapists, although name or any identifying details would not be disclosed.

Late or early arrival: if you arrive early please wait for your appointment time before calling, an early arrival may interfere with a previous client's appointment or interrupt preparation time. If late for an appointment your service will remain and complete at the original agreed time, with no adjustment to the fee.

Guarantees: There are a number of complex factors influencing the success of individual therapy and whilst benefits are typically observed in the majority of cases there can be no guarantees of success or cure in relation to a condition or its treatment.

Recording: I understand that sessions may be recorded both visually and auditory for the safeguarding of both the client and the AFLP Staff. Under GDPR these recordings are securely kept for up to eight years under secure conditions.

MEDICAL

Are you/your ward taking anti-depressants	Y	N
Do you/your ward suffer from Asthma	Y	N
Do you/your ward suffer from Diabetes	Y	N
Do you/your ward suffer or have you ever suffered from Epilepsy	Y	N
Are you/your ward takin tranquilisers	Y	N
Are you/your ward taking sleeping pill	Y	N

The above information is a true and accurate account.

CLIENT SIG: RELEVANT AFLP STAFF SIG:

GUARDIAN NAME: GUARDIAN SIG: (IF UNDER 18)