|  |  |  |  |
| --- | --- | --- | --- |
| **CYP Personal details** | | | |
| **Forename\*:** |  | **Surname\*:** |  |
| **(Preferred Name):** |  | **Gender\*:** | Male  Female  Prefer not to say  Other  (if other, please specify): |
| **Date of Birth\*:** |  | **Year group:** |  |
| **Ethnicity\*:** |  | | |
| **Home address**  **(including postcode)\*:** |  | | |
| **Physical Disability:** | ☐ Yes  ☐ No  (if yes, please specify): | **Additional needs (e.g. SEN):** | ☐ Yes  ☐ No  (if yes, please specify): |
| **School/College name & address**  **(if attending):** |  | | |
| **School contact details:** |  | **Permission to contact if deemed appropriate?** | ☐ Yes  ☐ No |
| **Local authority status\*:** | ☐ Looked After Child  ☐ Care Leaver  Social Worker involvement  Early Help Worker | **GP Details**  **(including address)\*:** |  |
| **Social / Early Help Worker full name\*:** |  | | |
| **Contact number\*:** |  | **Email address\*:** |  |
| **Team leader name\*:** |  | **Team leader contact details\*:** |  |
| **Social/ Early Help worker aware of referral?** | Yes  No | **Permission to contact?** | Yes  No |

cid:307afde6-85a1-40c6-a447-36524b759ff7

**Referral form: Short Intervention Therapy**

*This referral form will need to be completed by a Social Worker (PA if care leaver is over 18) or Early Help worker, GP/Nurse or professional of CAMHS/NELFT*

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Carer contact details** | | | |
| **Forename\*:** |  | **Surname\*:** |  |
| **Primary care-giver?** | Yes  No | **Parent/carer aware of and consented to the referral?\*** | Yes  No |
| **Contact number** |  | | |
| **Email address** |  | | |
| **Home address (including postcode)** |  | **Permission to contact?** | Yes  No |

|  |  |  |  |
| --- | --- | --- | --- |
| **Emergency contact details (if different to above)** | | | |
| **Forename:** |  | **Surname:** |  |
| **Relationship to CYP** |  | **Parent/carer aware of and consented to the referral?** | Yes  No |
| **Contact number** |  | | |
| **Email address** |  | | |
| **Home address (including postcode)** |  | **Permission to contact?** | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Referral details** | | |
| **Is CYP currently receiving therapy/support?** | ☐ Yes  ☐ No  If yes, what is the support? | **Please note, if the CYP is currently engaged in any form of therapy, they will not be able to access this service until that comes to an end.** |
| **Preferred therapy\*:** | ☐ Cognitive behavioural therapy (CBT)- Explores negative thought patterns and behaviours (e.g. Anxiety or low mood)  ☐ Dialectical behavioural therapy (DBT)- Explores difficult feelings and intense emotions  ☐ Creative therapy (i.e. arts, Lego etc.) | |
| **Provision of Therapy:** | **As part of the SIT service we offer individual and group therapy.** Referrals will be assessed internally and assigned services most appropriate for needs. Please note: CYP with an assigned Early Help Worker will be only offered group intervention. | |
| **Is CYP aware of and in agreement of referral?\*** | ☐ Yes  ☐ No  If no, why? | |
| **Mental health diagnosis/ Primary mental health concern** | ☐ Yes  ☐ No  If yes, please provide details (including any current medication) | |
| **Why are you referring this CYP/ what are the desired outcomes, objectively?** | | |
| **What does the CYP wish to achieve/ want to be different from accessing the support?**  Please provide as much detail as possible, this information will be used alongside the internal assessment to triage into appropriate therapy. | | |
| **What interventions have already been accessed by this CYP in response to their difficulties/ what support is currently in place?** (including Life Story Work) | | |
| **Is CYP currently at risk of harm to themselves or others?**  ☐ Yes  ☐ No  If yes, please provide details (i.e. self-harm, suicidal thoughts, suicidal intent etc.) | | |
| **Are there any current (or historic) safeguarding concerns relating to this CYP?**  (including where CYP has Child In Need Status, is on a Child Protection Plan or has experience of domestic abuse/violence)  ☐ Yes  ☐ No  If yes, please provide details | | |
| **Are there any current police investigations relating to this CYP?**  ☐ Yes  ☐ No  If yes, please provide details: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer details** | | | |
| **Forename:** |  | **Surname:** |  |
| **Organisation:** |  | **Date referral form completed:** |  |
| **Contact number:** |  | | |
| **Contact email:** |  | | |

For data protection reasons, referral forms must be sent either encrypted, or with a password protection (with subsequent password sent in a follow up email) to: [shortinterventiontherapy@northkentmind.co.uk](mailto:shortinterventiontherapy@northkentmind.co.uk)

Referral forms can also be physically handed to reception at: North Kent Mind, The Almshouses 20 West Hill, Dartford DA1 2EP.

CYP must remain open to Social Care or Early Help **throughout the duration of support** of the SIT service.

Should you have any queries, please contact the CYP SIT Coordinator, Kezia Murphy, at: keziamurphy@northkentmind.co.uk