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| **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 |



**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*

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| **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 |

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|  **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 |

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| **Referral details** |
| **Is CYP currently receiving therapy/support?** | ☐ Yes☐ NoIf 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☐ NoIf no, why? |
| **Mental health diagnosis/ Primary mental health concern** | ☐ Yes☐ NoIf 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☐ NoIf 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☐ NoIf yes, please provide details  |
| **Are there any current police investigations relating to this CYP?** ☐ Yes☐ NoIf yes, please provide details: |

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| **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

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