

Please ensure that all sections of this form are complete.

Referral form for Fairbridge under 16 Active Steps Project

Name of young person

Name of referrer

Date of referral

Date of Pupil Support Group

Referrers email address

Referrers work mobile

Referral Form

STRICTLY CONFIDENTIAL

For use in referring young people to
Fairbridge under 16' Services



In accordance with Fairbridge policy and that of participating agencies, personal information held for referral purposes is shared with clients subject to certain objections in terms of the Access to Personal Files Act. Donors of information relating to clients should indicate whether part or all of such information may be shared or should be restricted

Please return to Fairbridge Edinburgh, 73 Ferry Road, Edinburgh, EH6 4AQ

March 2009

SCHOOL **SOCIAL WORK DISTRICT**

(if permanently excluded, not attending, transferring or awaiting a place, name school which has pupil on it's roll)

1 Please tick the appropriate box to indicate if this is a new or a re-referral

2 **Name of Young Person** **Date of Birth**
Address **School Year/Class**
 Male **Female** **Position in Family** /
postcode **Tel**

Parent or Carer's Name and contact number (and address if different)
School Leaving Date

GP Name **S/Worker name/based at:**

School and Guidance Teacher's name
Is the school aware of referral? YES/NO

Please sign to confirm that the young person, the young person's parent or carer and the education provider has given permission for the referral to be made and information shared.

Name of referrer **Agency name, address & Contact Number.**
Date or referral **Signed**

3 REASONS FOR REFERRAL (if ticking more than one box, double tick to indicate main concerns)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> School Behaviour | <input type="checkbox"/> Relationship With Peers | <input type="checkbox"/> Care Issues | <input type="checkbox"/> Young Carer |
| <input type="checkbox"/> Risk of Exclusion | <input type="checkbox"/> Gender Issues | <input type="checkbox"/> Bereavement | <input type="checkbox"/> Minority Group Status |
| <input type="checkbox"/> Learning Needs | <input type="checkbox"/> Medical | <input type="checkbox"/> Previous permanent exclusion | <input type="checkbox"/> 'Looked After' at home |
| <input type="checkbox"/> Low attendance (enclose Phoenix) | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Currently excluded | <input type="checkbox"/> 'Looked After' away from home |
| <input type="checkbox"/> Aggression/aggressive behaviour | <input type="checkbox"/> Self Harm | <input type="checkbox"/> Child Protection | <input type="checkbox"/> Other withdrawal risk (please specify below) |
| <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Alcohol/Drug Misuse | <input type="checkbox"/> Domestic Violence | <input type="text"/> |
| <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Disengaged from curriculum | <input type="checkbox"/> Offending/charges | |

Please expand on the nature of the young person's difficulty and explain why you have ticked the above boxes. (continue on a separate sheet, and refer to attached background reports if applicable)

4.SUPPORT STRATEGIES

Please indicate which strategies are currently in place by putting 'C' in the appropriate box/es, and those previously used by putting 'P' in the appropriate box/es.

SCHOOL BASED

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Learning Support | <input type="checkbox"/> School Medical Services | <input type="checkbox"/> Alternative Timetable | <input type="checkbox"/> Pupil Support Group |
| <input type="checkbox"/> Support Base | <input type="checkbox"/> Psychological Services | <input type="checkbox"/> Education Welfare Officer | <input type="checkbox"/> Area Attendance Advisory Group |
| <input type="checkbox"/> Mainstream Transfer | <input type="checkbox"/> Hosting | <input type="checkbox"/> Outreach Teaching | <input type="checkbox"/> Home Link |
| <input type="checkbox"/> College Placement | <input type="checkbox"/> School Unit (please specify) <input type="text"/> | <input type="checkbox"/> Group work | |
- (eg Link, Panmure, Woods etc)

NON-SCHOOL BASED

- | | | |
|--|---|---|
| <input type="checkbox"/> Reporter/Children's Hearing | <input type="checkbox"/> Medical Services | <input type="checkbox"/> Children & Families Mental Health Services (eg YPU) |
| <input type="checkbox"/> Social Work Involvement | <input type="checkbox"/> Extended Work Experience | <input type="checkbox"/> Inter Agency Assessment |
| <input type="checkbox"/> Community Education | <input type="checkbox"/> Family Working | <input type="checkbox"/> Voluntary Agencies (please Specify) <input type="text"/> |

Please comment on the effectiveness of the above (e.g. give details, time scales, etc).

Please say how the young person and their parent/s or Carer/s view the referral.

Please state what you hope s/he would gain from the service you are requesting. Please include specific targets.

IN YOUR OPINION WOULD FAIRBRIDGE NEED TO CARRY OUT A RISK ASSESSMENT BEFORE WORKING WITH THIS YOUNG PERSON? YES/NO

PLEASE GIVE DETAILS: