

**Date of Referral**:

**Return by email to:** [**referrals@risingsunkent.com**](mailto:referrals@risingsunkent.com) **using password protection**

**CYP Referral: For children and young people aged 5-24 years only**

To password protect a word document, go to ‘File’ in the upper left hand corner, locate the icon labelled ‘Protect Document’ and click the dropdown menu. Then click ‘Encrypt with Password’ and follow the instructions. Please ensure to send the password in a separate email to the referral. Alternatively you can call our phone line to give the password.

***The Rising Sun Domestic Abuse Service*** is a charity in Kent addressing domestic abuse and providing services for adults, children and families. We seek to provide clients experiencing current or historical abuse with trauma informed emotional support, safety planning advice and the tools to develop healthy future relationships.

**Please fill in all fields. If the form is incomplete, it may be sent back. (Please indicate if question is not applicable)**

For guidance on completing this form, including which areas we currently provide services for, please read the accompanying guidance sheet.

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| 1. **Agency / Referrer Details** | |
| Referring agency: | |
| Contact Name: | Contact Role: |
| Contact Number: | Contact Email: |
| Please cross box if Self-Referral  Please cross box if Parent/ Carer Referral | If Self-Referral or Parent/ Carer referral, where did you hear about this service? |

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| 1. **Child/ Young Person Details**   **NOTE: if you are referring siblings, a separate form needs to be completed for each child** | | | | | | | |
| NAME OF Child/ Young Person  ON TRACK NUMBER: \*If internal RS referral\* | D.O.B: | | Age: | | Gender: | | Ethnicity: |
| Child/ Young Person’s Phone Number (if applicable) | Safe to phone:  Yes  No | | | Safe to leave a voicemail:  Yes  No  Safe to text:  Yes  No | | Safe time to call/text: | |
| Name of Parent/Carer:  ON TRACK NUMBER: \*If internal RS referral\* | DOB: | | | Age: | | Gender: | |
| For this referral, please contact: (cross one)  CYP directly  Parent/ Carer | | | | | | |
| Parent/ Carer’s Phone Number (if young person is under 16 years old) | Safe to phone:  Yes  No | | | Safe to leave a voicemail:  Yes  No  Safe to text:  Yes  No | | Safe time to call/text: | |
| Client Address (inc. postcode): | | | | Permission to write: Yes  No  Safe to write: Yes  No | | | |
| Current District/ Area: Ashford  Canterbury  Folkestone & Hythe  Swale  Other - Please specify: | | Local Authority of origin (if different): | | | | | |
| Safe email address: **(this is how we will update client on referral so please include, must be an email account the perpetrator does NOT have access to)** | | | | Is this for the child/ Young person? Yes  No  If no, who’s is it?  Safe to send an email: Yes  No | | | |

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| 1. **School Details - please be sure to include** | | |
| Name of School attended: | School phone number: | Year Group: |
| Address: | Name of contact at School:  Direct contact details: | |

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| 1. **Family Details** | | | |
| **Is this young person a parent?** Yes  No  (if yes, please give details below) | | | |
| **Names of anyone that lives/ frequently stays in the home including children: (if applicable)** | **Relationship with child/ young person referred** | **D.O.B and/or Age** | **Gender** |
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| 1. **History of Domestic Abuse** | | |
| **Name of alleged perpetrator**: | **D.O.B**: | **Address**: |
| **Child/ young person’s relationship with alleged perpetrator (tick multiple if more than one)**  Dad  Mum  Partner  Ex-Partner  Other  *If yes, please give details:* | | |
| **What contact does the child/ young person have with the alleged perpetrator:** | | |
| **Are there any court orders in place?**  Prohibited Steps  Non-molestation  Contact Arrangements  Other  *If yes, please give details:* | | |
| **Please tell us about the child/ young person’s experience of domestic abuse:** | | |
| **Please outline any current/ ongoing risks of domestic abuse and how they are being managed:** | | |

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| 1. **Client support needs** |
| **Agencies involved (mental health):**  CAMHS  School Counsellor  Other therapeutic/ support service  *If yes, please give details:*  *Please provide details of any diagnosis or any other details that may be helpful:* |
| **Is the child/ young person currently open to social services or early help? Please tick:**  Social Services  Early Help  *Please give details of any Social Workers:* |
| **Does the child/ young person have any history of criminal offences?**  Yes  No  Don’t Know  *If yes, please give details:* |
| **Does the child/young person have any kind of disability, including any neurodevelopmental disabilities/ SEN needs (such as Autism, ADHD)?**  Yes         No         Don’t Know    *If yes, please give details:* |
| **Does this child/young person have any accessibility requirements? (for example hearing loop, braille, BSL interpreter)**  Yes        No           Don’t Know    *If yes, please provide details:* |
| **Does this child/young person require an interpreter?**  Yes  No  Don’t Know  *If yes, please provide details:* |
| **Does this child/young person have a preference between face to face or remote support?**  Prefer remote  Prefer face to face  No preference |
| **Please outline any other current/ ongoing risks and how they are being managed (eg. Dropping out of school, involvement in gangs, risk of offending etc.):** |

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| 1. **REASON FOR REFERRAL:** |
| **What has the child/ young person directly or indirectly experienced:** |
| **Any changes in behaviour that have led to your concern:** |
| **What strengths does the child/ young person have:** |
| **What does the child/ young person wants to gain from this support:** |

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| 1. **SERVICE:** |
| **If you feel a particular service would be most beneficial for the child/young person, please tick the appropriate box in this section, and explain why.**  **You can view the different services on our website** [**https://www.risingsunkent.com/services/our-services/**](https://www.risingsunkent.com/services/our-services/)  **☐ Outreach support (16-24 girls with DASH risk score of 10+ (medium risk) / submit DASH with referral form)**  **☐ 1-1 Mentoring**  **☐ Group**  **☐ Counselling**  **Why?** |
| **Has this referral been discussed with the child/ young person and/or their parent carer?**  Yes        No     **Please tick to confirm who has given their consent (you can tick both)**  Child/ Young Person  Parent/ Carer |

**PLEASE NOTE: The contents of this form will be discussed with the child/ young person and, where appropriate, with their named parent/ carer at assessment.**