

**EARLY YEARS AND YOUNG PEOPLE SUPPORT SERVICES REFERRAL FORM**

**Please send completed forms to** **EarlyYearsandYoungPeople@bridgend.gov.uk**

**Consent**

***Early Years and Young People Support Services are voluntary - any referral submitted without parental consent will not be accepted.***

**Do you have consent from the parent/carer to submit this referral?**

 YES [ ]  NO [ ]

**Identified needs (select all that apply):**

|  |  |  |
| --- | --- | --- |
| Self-esteem/confidence |[ ]  Gender identity support |[ ]  Attachment disorder |[ ]
| Anger management |[ ]  Transition (school to college) |[ ]  Motivation |[ ]
| Social skills |[ ]  Personal safety |[ ]  Independent living skills |[ ]
| Isolation |[ ]  Travel training |[ ]  Coping strategies |[ ]
| Anxiety/stress/low mood management |[ ]  Persistent absence |[ ]  Employment skills |[ ]
| Housing |[ ]  Early language development and play skills |[ ]  Wellbeing |[ ]
| Exploitation |[ ]  Access to childcare |[ ]  Other, please specify |  |

**Identified service area (select all that apply):**

|  |  |
| --- | --- |
| Family Engagement Officer |[ ]  Health and Wellbeing Team |[ ]
| School Based Counselling |[ ]  Early Years and Childcare |[ ]
| Community Counselling |[ ]  Basic Skills |[ ]
| Inspire to Achieve + |[ ]  Language and Play |[ ]
| Prevention of Youth Homelessness Team |[ ]  Inspire to Work + |[ ]
| Youth Emotional Health Team |[ ]  Other/not known |[ ]

**For child protection referrals please complete MASH referral form and send to:** Mashcentra@bridgend.gov.uk

**Date of referral:** Click or tap to enter a date.

1. **Details of person completing request:**

|  |  |
| --- | --- |
| Name:  | Email: |
| Agency/designation:  | Telephone:  |

1. **Family/young person contact details:**

|  |  |
| --- | --- |
| Referred child: |  |
| Home address: |  |
| Telephone: |  |
| Email: |  |

1. **Family details** – please provide details of all relevant family members:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Live in household (Y/N)(if no - please provide details below) | Name of nursery/ school/college | Relationship to child(children) referred | Date of birth | Gender |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

*(Tab down to increase rows)*

**Please provide any additional family member details in the space below (for example address if not living within household)**

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|  |

1. **Family disabilities:**

**Are there any additional needs relating to disability within the family**  YES[ ]  NO [ ]

**How many individuals within the family have additional needs relating to disability** Choose an item.

**Is any family member deaf and/or blind?** YES[ ]  NO [ ]

**If you have answered yes to any of the questions relating to disability, please provide full details below:**

|  |
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1. **Agency involvement**

**Is the family currently open to Children’s Social Care?** YES[ ]  NO [ ]

**Is the family currently open to any other services?** YES[ ]  NO [ ]

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| --- |
| If yes, please list all services in the box below |
|  |

1. **Why do you consider the requested intervention is needed for this child/young person/family?**

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| --- |
| What are the worries for this child/young person/family? What has happened or what have you seen that has made you worried about this child / young person (past and current worries)? |
|  |

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| --- |
| What’s going well for the child/young person/family? For example, positive adult relationships (family, school, community), peer friendships, engaged in learning, interests, hopes, ambitions, positive outlook and sense of self, good problem solver. |
|  |

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| --- |
| What additional help do you consider this child/young person/family needs to effect change? |
|  |

**7. Risk assessment**

**Are there any known risks relating to any person connected with this referral?** YES[ ]  NO [ ]

|  |
| --- |
| If yes to any of the above please provide full details (for example threats towards staff, history of domestic violence, substance misuse, exploitation) |
|  |