

**THE LINK REFERRAL**

Name of Referrer:............................................. Referring Agency:.................................................

Designation of Referrer:...........................................................................................................................

Address:......................................................................................................................................................................................................................................................................................................................

Tel No:................................................................ Fax:............................................................................

Email..................................................................... Date:.......................................................................

**CHILD/YOUNG PERSON’S NAME AND ADDRESS**

|  |  |  |
| --- | --- | --- |
| Forename: | Surname: | Gender |
| Address: | Tel No: | D.O.B: |
| Mobile No: | NHS No: |
| Parent/Guardian email: | Preferred method of contact:  Ο Landline Ο Post  Ο Email Ο Mobile | |

**GP & SCHOOL DETAILS**

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| --- | --- |
| Name of GP:  Address of Practice: | Name of School/College  Address: |
| Contact Number: | Contact Number: |

**ETHNIC DETAILS**

Ο White British Ο White & Black Caribbean

Ο White Irish Ο White & Black African

Ο Other White Background Ο White and Black Asian

Ο Chinese Ο Other mixed background

Ο Indian Ο Kasmiri

Ο Pakistani Ο Caribbean

Ο Bangladeshi Ο African

Ο Other Asian background Ο Other Black background

Ο other ethnic groups – please specify...............................................................

|  |  |
| --- | --- |
| Child/Young Person’s First Language: | Parent’s First Language: |

**ADDITIONAL INFORMATION**

|  |  |
| --- | --- |
| Does the Child/Young Person have a Statement of Special Education Needs?  Ο Yes Ο No  Details: | Has/is the Young Person accommodated by a Local Authority?  Ο Yes Ο No  Details: |
| Has/is the Young Person on Child Protection Plan?  Ο Yes Ο No  Details: | Does the Child/Young Person have a CAF in place?  Ο Yes Ο No  If so, please attach a copy. |
| Does the Child/Young Person have Pastoral Support?  Ο Ο No  Details: | Child in Need  Ο Yes Ο No  Details: |

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| Other Agencies Involved: |
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| Reason for Referral: |
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| Do you have any Accessibility requirements: Ο Yes Ο No |
| If yes, please provide details: |

*Please note: if the young person is Gillick competent, parent/carer consent is not mandatory.*

I agree with this request being submitted to The Link and that in accepting this request, information will be shared between agencies (NHS CAMHS, The Link, The Junction Foundation, Middlesbrough & Stockton Mind, Time 4 U Counselling, InsideOut MHST) to ensure appropriate assessment is completed and practitioners identified.

We reserve the right to change our decision and will inform the referrer of this action immediately.

Signature of Parent/Carer: Date:

Print Name:

Signature of Young Person: Date:

Print Name: