**Therapy services**

**Child bereavement services referral form**

Please be aware that unless otherwise specified all fields are compulsory and forms will be returned if insufficient information is provided.

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| --- | --- | --- | --- | --- | --- | --- |
| **Details of young person being referred** | | | | | | |
| Title: |  | | | | Home Address and Postcode: |  |
| Forename: |  | | | |
| Surname: |  | | | |
| Date of birth: |  | | | |
| Home telephone no |  | | | | Address and Postcode at time of Referral (if different): |  |
| Mobile no |  | | | |
| Can messages be left? | Home: | Y/N | Mob: | Y/N |
| Email: |  | | | |

|  |  |
| --- | --- |
| **Accessibility information** | |
| Preferred language: |  |
| Access needs: |  |
| Other requirements: |  |

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| --- | --- | --- | --- |
| **Demographic information**  This information is used for monitoring purposes and to signpost service users to relevant services. Any information given should be determined by the person being referred, given voluntarily, and will be stored confidentially in line with data protection laws. | | | |
| Gender: |  | Faith or religion: |  |
| Ethnicity: |  | Sexual orientation: |  |

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| --- | --- | --- |
| **Safeguarding** | | |
| Any known risks? |  | |
| Has the person being referred consented to this information being shared? | | Y/N |

**Personal and referrer details**

|  |  |
| --- | --- |
| **Referred by** | |
| Name: |  |
| Role: |  |
| Organisation: |  |
| Address: |  |
| Phone number: |  |
| Email address: |  |

|  |  |
| --- | --- |
| **Parent/carer information** | |
| Name: |  |
| Relation: |  |
| Address: |  |
| Phone number: |  |
| Email address: |  |

|  |  |
| --- | --- |
| **GP information** | |
| GP name: |  |
| GP practice: |  |
| Surgery address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| **School/college information** | |
| School/college: |  |
| School/college address: |  |
| Contact name: |  |
| Phone number: |  |
| Email address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Family members** | | | |
| Name | Relation | Age if Known | Is support required?  (YES/NO) \* |
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**\*Please be aware that the above does not serve as a referral for additional family members. We would still require individual referral forms.**

|  |  |
| --- | --- |
| **Referral information** | |
| **REASONS FOR REFERRAL**  (please provide as much detail as possible about the bereavement(s) experienced by the young person including: date of bereavement; their relation to the individual; circumstances surrounding the death; and if they found the body?) |  |
| **CURRENT CONCERNS AT HOME/SCHOOL**  (please provide as much detail as possible about current behaviours and onset of these, emotions, impact on daily life and relationships) |  |
| **OTHER SERVICES CURRENTLY INVOLVED WITH FAMILY OR CHILD/YOUNG PERSON** |  |
| **ANY OTHER DETAILS YOU WOULD LIKE US TO KNOW AT THIS STAGE** (E.g. Medical conditions, medication, formal diagnosis, any other current crisis issues in family) |  |

**Please indicate if any of the below are applicable:**

**About the young person:**

* The young person currently self-harms
* The young person currently has suicidal thoughts
* The young person has had suicidal thoughts, and acted on these, in the past 12 months
* The young person has learning difficulties, which prevent them from engaging verbally with people they don’t know very well
* The young person (for 16- and 17-year olds) is not seen to have capacity
* The young person has an enduring mental health condition(s), with a diagnosis
* The young person has experienced hallucinations, delusions, or has had a psychotic episode in the last 12 months
* The young person currently misuses alcohol or other substances
* The young person is currently involved in legal action

**About the home and family:**

* Domestic violence in the home
* The young person is currently in care
* There is a child protection plan currently in place
* A family member/someone in the home is serving (or has served) a custodial sentence
* Current criminal charges
* Any other legal issues

**Please use the space below to provide any additional details:**

**Consent to referral and contact by Gaddum**

* **This form will not be accepted without the consent of the young person/family**
* **Direct contact details are needed for young people aged 16 or 17, as they will be contacted directly following referral**
* **For referrers:** If you are not with the family/young person at the point of referral, please ensure that you have gained consent for them to be referred and for them to be contacted by Gaddum – and select the appropriate option below.

**Direct consent:**

Do you consent to this referral, and being contacted via any of the contact methods provided on this form (including receiving text appointment reminders)?

⃣ Yes ⃣ No

If not, please let us know how you would like to be contacted below (please be aware that if we are unable to reach you within 10 working days of the referral your case may be closed):

**Does your child/young person consent to this referral?**

**⃣** Yes ⃣ No

**Parent or Carer’s signature or signature of young person (16/17 years old):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent gained by referrer:**

Does the family and/or young person consent to the referral and consent to being contacted via any of the contact methods provided on this form (including text appointment reminders)?

**⃣** Yes ⃣ No

If not, please let us know how the family would like to be contacted below (please be aware that if we are unable to reach the family within 10 working days of the referral the case may be closed):

**Please complete and return to** [**referrals@gaddum.org.uk**](mailto:referrals@gaddum.org.uk) **or post to Therapy Services, Gaddum, 6 Great Jackson St, Manchester M15 4AX.**

**You can also call: 0161 834 6069 with any queries about our services.**