

Compass Phoenix offer support and interventions for children and young people aged 9-19 (and up to 25 for those with special educational needs or disabilities) who are experiencing mild to moderate mental health difficulties. Support for key stages 3 and above is predominantly delivered via virtual groups, and for those under 13 we offer a digital platform. 1:1 interventions are delivered by exception where appropriate.

We also offer a Professional Consultation to school and college staff, providing advice and guidance on emotional wellbeing and mental health to help make sure that children and young people get the right support at the right time in the right place. We would recommend that schools/colleges use this service before making a referral by calling 01904 661916.

Before submitting this referral please review the THRIVE framework to identify if Compass Phoenix is the right service to support the young person.

In order for referral to be accepted the young person must meet *at least one* of the following criteria:

* Reside in North Yorkshire (excluding the city of York)
* Registered with a GP in North Yorkshire
* Enrolled in an education setting within North Yorkshire

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| **CONSENT** |
| Please note by completing this referral, Compass will expect the following of the referrer (please tick to confirm): **This referral has been discussed and consent obtained from the young person or parent/carer under 13 years: Yes** [ ]  **No** [ ] **If the young person is 13 years or over, do you consider them to have capacity to give informed consent: Yes** [ ]  **No** [ ] **You have explained that any information held on this form will be stored by Compass on a secure database: Yes** [ ]  **No** [ ] **Is the young person’s parent / carer aware of the referral? Yes ☐ No ☐****If 13 years or over, does the young person consent to contacting parent/carer? Yes ☐ No ☐ (Please be aware that in the event of safeguarding concerns contact will be made with parent/carer)****Signed by referrer:………………… Signed by service user or parent / carer :………………..…..****If the boxes above have not been completed and/or the consent is not given, the form cannot be processed and will need to be returned to you** |

**Please ensure that all mandatory fields\* are completed before submitting the referral as we are unable to process referrals without this information.**

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| **CONTACT DETAILS OF THE YOUNG PERSON** |
| **Legal name\*:**  | **Preferred name/ pronoun:**  |
| **Address & postcode\*:**  |
| **E-mail address:** |
| **Telephone number:**  |
| **Date of birth\*:**  | **Age:** |
| **Gender Assigned at Birth\*:** | male / female (delete as appropriate) | **Gender Identity:** | male / female / transgender / non-binary/ I describe myself in some other way / prefer not to say (delete as appropriate) |
| **Ethnicity:**  |
| **Correspondence will be by e-mail, telephone or letter unless you state otherwise:** |
| **CONTACT DETAILS OF PARENT/ CARER or SIGNIFICANT OTHER** |
| **Name including title\*:**  | **Relationship to young person:** |
| **Address & postcode (if different to the young person)\*:** |
| **E-mail address\*:** |
| **Telephone number\*:** |
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| **EDUCATION DETAILS** |
| **Name of the education setting or other provision\*:**  |
| **Name of key contact / member of staff:**  |
| **Contact telephone number:**  | **Email address:** |
| **CONTACT DETAILS OF REFERRER** |
| **Name\*:**  | **Relationship to young person\*:**  |
| **Organisation\*:**  |
| **Telephone number\*:**  | **Email address\*:**  |
| **GP DETAILS** |
| **Name of G.P surgery\*:** |

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| **Phone Number:** | **Email address:** |

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| Stress |[ ]  Feelings of anger |[ ]
| Bullying |[ ]  Self-harm | [ ]  |
| Anxiety |[ ]  Body image |[ ]
| Low mood |[ ]  Eating problems |[ ]
| Self-esteem |[ ]  Bereavement/loss |[ ]
| Social Isolation |[ ]  Suicidal thoughts |[ ]
| Other (please give details): |

**Please tick ONE which is the main presenting need / problem:** |
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| --- | --- |
| Stress |[ ]  Feelings of anger |[ ]
| Bullying |[ ]  Self-harm | [ ]  |
| Anxiety |[ ]  Body image |[ ]
| Low mood |[ ]  Eating problems |[ ]
| Self-esteem |[ ]  Bereavement/loss |[ ]
| Social isolation |[ ]  Suicidal thoughts |[ ]
| Other (please give details):**Give a brief description about what the young person would like support with:**  |

**Please tick any other problems:** |
| **Are you aware of any current or previous risks associated with this young person? If you have an existing risk assessment for your service please attach:** |
| **To self:**  | **From others:**  |
| **To others:**  | **General:**  |
| **List any other agencies involved in supporting young person, (please provide contact details if known):** |
| **Current:** | **Past:** |
| **Are there any additional needs we need to be aware of:** |
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| **Are there any family and social relationship issues relevant to this referral?** |
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| **Once completed please email the completed referral form to:** |
| **Secure\* email address:** **compass.phoenix1@nhs.net** \*NB In order for this to remain secure you must use an NHS email address  |
| **Alternative email address:** **phoenix@compass-uk.org** |
|  **Secure\* email address:** **compass.phoenix@compassuk.cjsm.net**\*NB Secure email address (should be used whenever possible to ensure confidentiality – **you will need a CJSM account for this**) |