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| 1. **Privacy Notice Statement & CONSENT** |
| **Please note by completing this request for support form, Compass will expect the following (please tick to confirm):**   1. This referral has been discussed and agreed with the person concerned 2. You consider the person to have capacity to give informed consent 3. If the person does not have capacity to consent, you have consulted with the parent/carer/advocate. 4. You have explained that any information held on this form will be stored by Compass on a secure database   **If the referral is for a young person:**   1. Does the parent/carer (if under 16) or young person, consent to Compass contacting other agencies to discuss the referral if required? Yes  No 2. Does the child/young person consent to us contacting their parent/carer?Yes  No   **PLEASE NOTE: We will be unable to progress with a request for support without confirmation that consent has been appropriately discussed and agreed.** |

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| **Compass Wakefield Emotional Wellbeing Service** provides early intervention and support to children, young people, families and communities to develop the knowledge, skills and confidence to build and maintain the emotional health and wellbeing of children and young people.  Helpful topical information, advice, and self-help materials are easily available at [www.wf-i-can.co.uk](http://www.wf-i-can.co.uk)  The service provides a free texting service in partnership with SHOUT 24 hours a day, 7 days a week for confidential help. To access this service text **BUZZ** to **85258**.  The service provides tailored advice and information and/or guided self-help through goal-based interventions on either an individual or group basis. To access advice or support please contact us on **01924 665093** Monday – Friday 9.00am t0 4.30pm or complete the request for support form and return it to [WakefieldCYPEWS@Compass-uk.org](mailto:WakefieldCYPEWS@Compass-uk.org).  Please tick the box below indicating the purpose of your request:  To access emotional wellbeing support for a child or young person  To access bereavement support for a child or young person  To access family practitioner support  Advice and Information for: A child or young person  A parent or carer  Something else  Please tell us here about your request…………………………………………………………………………….  ……………………………………………………………………………………………………………………………………………………………..  ***Please note that it may hold up the referral if Compass is unable to speak with the referrer following this request.*** | | | | | | | |
| **CONTACT DETAILS FOR PERSON MAKING REQUEST** | | | | | | | |
| **Name:** | | | **Relationship:** | | | | |
| **Organisation (if applicable):** | | | | | | | |
| **Address:** | | | | | | | |
| **Contact phone number:** | | | | | | | |
| **E-mail address:** | | | | | | | |
| **Has the child/young person/parent/carer consented to being contacted via phone?** Yes  No | | | | | | | |
| **Has the child/young person/parent/carer consented to being contacted via text message?** Yes  No | | | | | | | |
| **Has the child/young person/ parent/carer consented to being contacted via email?** Yes  No | | | | | | | |
| **DETAILS OF THE PERSON REFERRED** | | | | | | | |
| **Full name** | | | | **Preferred name:** | | | |
| **Address:** | | | | | | | |
| (*NB we may correspond by post unless you instruct us not to)* **Postcode:** | | | | | | | |
| **Mobile phone number:**  (*NB we may leave a message on this phone number unless you tell us not to)* | | | | | | | |
| **Landline phone number:**  (*NB we may leave a message on this phone number unless you tell us not to)* | | | | | | | |
| **Date of birth:** | | | | | | **Age:** | |
| **Gender:** | | | | | | **Religion:** | |
| **Ethnicity:** | White British  White Irish  Any other white background  Mixed White and Black Caribbean  Mixed White and Black African  Mixed White and Asian  Any other Mixed Background  Asian or Asian British – Indian  Asian or Asian British – Pakistani  Asian or Asian British – Bangladeshi  Any other Asian Background | | | | Black or Black British – Caribbean  Black or Black British – African  Black or Black British – Other  Other Ethnic group – Chinese  Any other ethnic group (state)……………………..  **Main Language:**  (Is an interpreter required? If so specify language)  Documents required in main language | | |
| **Next of Kin:** | | | | | | | |
| **Accommodation status:**  (i.e. living with parents, living with relatives, fostered, adopted, independent living) | | | | | | | |
| **Are there any methods by which the person does NOT want to be contacted?** | | | | | | | |
| **Are there any additional needs Compass will need to be aware of to help the CYP/family engage?** This may include accessibility/hearing impairment/communication methods. | | | | | | | |
| **IF THE REQUEST IS FOR A PERSON UNDER 18 YEARS OF AGE PLEASE PROVIDE CONTACT DETAILS OF PARENTS / CARERS** | | | | | | | |
|  | | **Parent/Carer One** | | | | | **Parent/Carer Two** (optional) |
| **Name:** | |  | | | | |  |
| **Relationship:** | |  | | | | |  |
| **Address:** | |  | | | | |  |
| **Contact phone number:** | |  | | | | |  |
| **E-mail address:** | |  | | | | |  |
| **Main language:** | |  | | | | |  |
| **Is an interpreter required?** | |  | | | | |  |
| **SCHOOL/COLLEGE DETAILS (if applicable)** | | | | | | | |
| **Name of the school the young person attends:** | | | | | | | |
| **Year group:** | | | | | | | |
| **Name of key contact / member of staff at school:** | | | | | | | |
| **Telephone number of the school:** | | | | | | | |
|  | | | | | | | |
| **GP DETAILS** | | | | | | | |
| **G.P name:** | | | | | | | |
| **Name and address of G.P surgery:** | | | | | | | |
| **Phone number:** | | | | | | | |
| **Email address:** | | | | | | | |
|  | | | | | | | |
| **DOES THE PERSON HAVE ANY ADDITIONAL NEEDS** | | | | | | | |
| Subject to a CPP | | | | | | Yes  No  Don’t know | |
| Elected Home Educated | | | | | | Yes  No  Don’t know | |
| LAC/Care Leaver | | | | | | Yes  No  Don’t know | |
| Young Carer | | | | | | Yes  No  Don’t know | |
| Excluded / at risk of | | | | | | Yes  No  Don’t know | |
| Substance Misuse | | | | | | Yes  No  Don’t know | |
| NEET | | | | | | Yes  No  Don’t know | |
| Free school meals | | | | | | Yes  No  Don’t know | |
| Financial hardship | | | | | | Yes  No  Don’t know | |
| Special Educational Need or Disability (SEND) | | | | | | Yes  No  Don’t know | |
| Neurodiverse Diagnosis (e.g. ASD, ADHD) | | | | | | Yes  No  Don’t know | |
| Education Health and Care Plan (EHCP) | | | | | | Yes  No  Don’t know | |
| Physical health needs (including allergies) | | | | | | Yes  No  Don’t know | |
| Mental health diagnosis (e.g. PTSD, OCD, anxiety, depression) | | | | | | Yes  No  Don’t know | |
| Previous mental health intervention (e.g. CAMHS, counsellor, Psychologist) | | | | | | Yes  No  Don’t know | |
| Please provide more details: **If you have ticked Yes to any of the above please provide further information** | | | | | | | |
| **PREVIOUSLY SUPPORTED BY:** | | | | | | | |
| CAMHS | | | | | | Yes  No  Don’t know | |
| Future In Mind | | | | | | Yes  No  Don’t know | |
| 0-19 School Nursing Service | | | | | | Yes  No  Don’t know | |
| I-SPACE | | | | | | Yes  No  Don’t know | |
| STAR Bereavement | | | | | | Yes  No  Don’t know | |
| Other (Please list): | | | | | | | |
| WHAT SUPPORT WAS DELIVERED, HOW MANY SESSIONS AND WHEN DID THIS SUPPORT END? | | | | | | | |

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| **cURRENT REFERRAL MADE TO THE FOLLOWING SERVICES:** | |
| CAMHS | Yes  No  Don’t know |
| Future In Mind | Yes  No  Don’t know |
| 0-19 School Nursing Service | Yes  No  Don’t know |
| I-SPACE | Yes  No  Don’t know |
| STAR Bereavement | Yes  No  Don’t know |
| Other (Please list): | |
| **what is the reason for referral?** | |
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| **Are you aware of any current or previous risks associated with working with this person?**  (please include any risks to self, others and safeguarding concerns) | |
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| **PLEASE TELL US ABOUT ANY OTHER SERVICES SUPPORTING THE FAMILY.** (This might include CAMHS, Early Help, School Nursing, social worker or others). | |
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| **Any other relevant information:**  (Including: family, social, educational factors, disability or communication needs) | |
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| **What is important to the person referred?** | |
| **What would you most like help with?** | |
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| **What sort of things do you find most difficult?** | |
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| **How would you like things to improve?** | |
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| Please send your completed Request for Support form, securely to: [WakefieldCYPEWS@Compass-uk.org](mailto:WakefieldCYPEWS@Compass-uk.org)  If you are unable to send the form electronically please contact Compass on 01924 665093 – Monday – Friday 09.00 – 16.30 hours. | |