**Programme Referral Form**

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| **Referrer’s Details** | **To be completed by Referrer** **All sections must be completed** |
| Programme referring to: |  |
| Name of and post held by Referrer: |  |
| Agency of referrer: |  |
| Referrer’s contact details:  | Email address: Mobile Tel No.:  |
| Date of Referral: |  |
| **Young Person Details** | **To be completed by Referrer**  |
| First Name: |  |
| Surname: |  |
| Preferred Name: |  |
| Address: |  |
| Post Code: |  |
| Who do they live with: |  |
| Parent/ Carer’s Name and Relation to young person  |  |
| Parent/ Carer’s Telephone Number: | Landline: Mobile: |
| Email address: |  |
| D.O.B: |  |
| Please log any known Disabilities or Medical Issues: | Allergies/ sensitivities/medications |
| Name and address of GP: |  |
| Emergency Contact Name and Number |  |
| Dietary requirementsEntitled to free school Meals  | YES NO |
| Ethnicity (please highlight): | White-British White-Irish White-OtherMixed-White and Black CaribbeanMixed-White and Black AfricanMixed-White and Asian Mixed-OtherIndian Pakistani Bangladeshi Asian-Other Caribbean African Black-OtherChinese Other Not Stated Not known |
| Preferred Language: |  |
| Religion (if known): |  |
| Gender: | Female Male Other  |
| Sexual Orientation (if known): | Heterosexual/Straight Gay LesbianBisexual Unsure  |
| Name of School or college: |  |
| School Contact person name: School Telephone number:  |  |
| Details of Social Worker and/or other Professionals involved: |  |
| Known risk factors- please be specific  |  |
| Known Addictions – Drugs, Alcohol, Gambling |  |
| Are there any causes for concern with their behaviour such as road safety, criminal convictions, running away, self-harm or harm to others? |  |
| Siblings name(s); Date(s) Of Birth(s); School they currently attended | Name DOB School Name DOBSchool |
| Parents details:(Name; Address; Risk Factors; relevant convictions) |  |
| Is the young person on any plans: (i.e CIN, CP, PLO)Please give details:  |  |
| Change of Circumstances within the next 12 months?  | Please provide any known changes the young person may encounter. School/ College/ Living address? |
| Details and dates of any interventions with the young person- currently receiving or in the last 6 months? |  |
| Has the young person been affected by any of the following?  | DV between child and Father DV between child and MotherDV Father abusing MotherDV Mother abusing FatherDV between parent and their partnerDV between child and extended familyCoercive or controlling behaviour Sexual AbuseAlcohol/ Drug MisuseDebt or unemployment concernsMental Health concernsAnti-social behaviourNO YES Details: |
| Has the young person been exposed to DVA in the last 2 years? | Within 2 years                           Over 2 years   |
| Reason for Referral:Please give details |  |
| **Thank you for the information provided. The Referral will now be processed and a member of the team at RCT will contact the individual you have referred shortly to plan appropriate interventions** |

**Participant Consent**

As a participant on an RCT programme you will be asked to supply personal data in written form. This will include name, address, DOB, contact details and next of kin details. We may ask for additional information regarding the support you receive, professionals you work with and any other personal needs. Additionally, notes will be made from each session. Personal data that we collect from any source will be kept securely on an online database.

Under the GDPR and Data Protection Act 2018, you are entitled to view, amend, or delete the personal information that we hold.

We cannot guarantee complete confidentiality because of our legal and ethical responsibilities and it may be necessary to break confidentiality;

* If you pose a risk of serious harm to yourself or another person
* If I believe a child or vulnerable adult is at risk of harm or abuse
* If you share information about a serious crime that has not previously been disclosed to the authorities.
* If it is in the client’s best interests and they are not able to consent for themselves.
* Where there is a legal obligation to do so.
* When requested by a client’s insurance company in respect of a claim
* Where partner agencies may need the information to provide further support.

In these case’s information can be passed to the relevant partner agencies, Social services, GP and emergency Services.

Information may also be shared with agency partners and other support professionals that are involved in your care. This is to enable a multi-agency approach and the best possible support.

By signing this agreement, you are providing your permission for us to obtain and/or share information about you and people in your care. This also applies to any information you may disclose during our sessions together and consents to RCT sharing relevant information to partner agencies.

I must ask you to sign below to state you understand what you have been informed. Failure to sign will result in the termination of this meeting and of us working together.

Name of young person (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (parent/carer if under 16): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **Continuing Service Requirements**

**An exit strategy should set forth the Organisation’s service requirements for the period during which the parties are transitioning out of the relationship. These requirements may include:**

* **An obligation by the supplier to continue performing the services at the same level of quality for the transition period and to continue to comply with all the obligations in the contract.**
* **Requirements for the provision of parallel services for a certain period, with the right to extend the term as necessary to resolve issues before the final cutover.**
* **An obligation by the supplier to keep the same supplier team performing services during the transition period.**
* **Confidentiality on any communications regarding the termination of the relationship.**

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**Photo Consent Form**

We would be grateful if you would fill in this form to give us permission to take photos/audio and use these in our printed and online publicity.

I give permission to Rochdale Connections Trust to take photographs and / or audio/video of my child/young person.

I grant Rochdale Connections Trust full rights to use the images resulting from the photography/video filming, and any reproductions or adaptations of the images for fundraising, publicity or other purposes to help achieve RCT’s aims.

This might include (but is not limited to), the right to use them in their printed and online publicity, social media, press releases and funding applications.

If you would like to limit or restrict the usage of photography please state your preference:

(I.E. photos can be used for funding purposes but may not be used for social media, I am happy for my child to participate in audio recordings that are anonymised)

|  |  |
| --- | --- |
| Name of young person  |  |
| Relationship to young person (e.g. parent, guardian, responsible adult): |  |
| Name of parent / guardian |  |
| Signature of parent / guardian |  |
| Date |  |