**A picture containing food, drawing

Description automatically generatedCYP Support Form**

**Please read the following guidance.**

By completing this referral form, you’re helping us to make contact safely and quickly. Please ensure that you include as much information as possible - this saves the family being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**How to submit this referral:**

Please submit this referral by emailing it to [childsupport@swindonwomensaid.org](mailto:childsupport@swindonwomensaid.org)

We will acknowledge receipt of the referral within 5 working days of receipt.

***Essential criteria when referring into this service:***

|  |  |
| --- | --- |
|  | **Please tick** |
| *Child or young person who have an awareness/understanding of, or who have experienced/witnessed domestic abuse within their home or the wider family.* |  |
| *Child or young person living in the Swindon area.* |  |
| *Child or young person not currently living with a perpetrator of domestic abuse**.* |  |
| *Child or young person who are willing to engage in support sessions with CYP staff from Swindon Domestic Abuse Support Service.* |  |
| *Child or young person displaying signs of emotional & behavioural issues as a direct result of exposure to domestic abuse.* |  |
| *Consent from the non-abusive parent/carer must be sought prior to referral.* |  |
| *Is the child or young person aware of the referral.* |  |
| *Age of child or young person (different services are available for different age groups)* |  |

|  |  |  |
| --- | --- | --- |
| 1. **Information about the person making the referral** | | |
|  | | |
| Date of referral: | |  |
| **Please indicate which service you’d like to refer to:** | | |
| 1:1 Outreach Support  CYP Recovery Toolkit (group programme)  I would consider either type of support for the CYP | | |
| **Please enter your name and contact details:** | | |
| Referrer’s name |  | |
| Organisation name |  | |
| Role/ job title |  | |
| Contact number |  | |
| Contact email |  | |

1. **Child or Young Person’s contact info.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child or Young Person’s Details** | | | | | |
| First name | |  | | | |
| Last name | |  | | | |
| Other names | |  | | | |
| What do they like to be called? | |  | | | |
| DOB | |  | | | |
| Current Age | |  | | | |
| **Parent/Guardian Details** | | | | | |
| Name of Parent/Guardian: | |  | | | |
| *Is it safe to directly contact this parent/carer? Yes No (please highlight)* | | | | | |
| Telephone Number | |  | | | |
| Contact Email Address | |  | | | |
| Current Home Address | |  | | | |
| Safe contact notes | |  | | | |
| **EMERGENCY CONTACT INFO**  **Next of kin if different to the parent/guardian** | | | | | |
| Name | |  | | Relationship |  |
| Contact information | |  | | | |
| Safe contact notes | |  | | | |
| **School/College info:** | | | | | |
| Which school/college does the child or young person attend? | |  | | | |
| If there is a pastoral worker or someone who is working with the family that is already aware and supporting this child or young person, please tell us their name AND contact details if possible. | |  | | | |
| **Safeguarding** | | | | | |
| Are children’s services involved in this case? | | Yes  No Don’t Know | | | |
| Level/ nature of involvement notes:  (If the child or young person has a social worker, please give us their name). | |  | | | |
| **Accessibility requirements** | | | | | |
| Does this child or young person have any accessibility requirements (for example, hearing loop, braille documents). | Yes  No  Don’t Know | | *If yes, please provide details:* | | |
| Do they have any allergies? | Yes  No  Don’t Know | | *If yes, please provide details:* | | |
| Does this child or young person require an interpreter? | Yes  No  Don’t Know | | *If yes, please provide details:* | | |

1. **Client Equalities Monitoring**

|  |  |
| --- | --- |
| How would this CYP describe their gender? | Female  Male  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| Is their current gender **different** to the sex they were assigned at birth? | Yes  No  Don’t know |
| Do they consider themselves to have any kind of disability?  (Please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Other *(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| How would they describe their ethnicity? | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other *(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| Do they have a faith/ religion? | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other *(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| If appropriate, what is their sexual orientation? | Heterosexual  Gay woman  Gay man  Bisexual  Other *(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  N/A |

1. **Child or Young Person Support Needs/ Vulnerabilities**

|  |  |
| --- | --- |
| **Please tell us more about any support needs the client may have:** | |
| Mental Health  Physical Health  Sexual Health  Substance misuse  Aggressive behaviour  Self-harming/ suicidal feelings | Educational attainment/ attendance  Social isolation  Bullying/ being bullied  Experiencing abuse  Other *(please specify below)* |
| **Additional details:** | |
|  | |

1. **Siblings**

|  |  |
| --- | --- |
| **Please provide names and DOBs for any siblings below:** | |
| Name | DOB |
|  |  |

1. **Information on Alleged Perpetrator**

|  |  |
| --- | --- |
| **Please provide us with the relevant details of the alleged perpetrator of abuse:** | |
| Name |  |
| Relationship to young person |  |
| Date of Birth |  |
| Address |  |
| Is the young person still in contact with the alleged perpetrator?  If yes, what contact and when? | Yes  No |
| *If there is more than one alleged perpetrator, please provide additional details in the box below:* | |
|  | |

1. **Reason for Referral**

|  |
| --- |
| **It is important that this section is completed in detail. Please consider these questions when completing this section:**  *What has been going on?*  *How long has this been going on for?*  *Can you tell me who is involved?*  *Please indicate the perpetrators relationship with the child or young person.*  *Is the child or young person having contact with the perpetrator of the domestic abuse? If so, please tell us more about that.*  *Tell us more about the behaviours, fears, worries or anxieties of the child and young person.*  *How do you think SDASS could help?* |
|  |
| **Are there any known risks to working with this child or young person?** |
|  |
| **Please tell us about any other support this child and young person is receiving and when this due to end, e.g., STEP, Seeking Solutions, CAMHS/TAMHS, ELSA etc** |
|  |

**How to get in touch:**

If you have any questions about our service, eligibility criteria, or how to make a referral, please contact:

Swindon Women’s Aid 24hr Helpline 01793 610610

SDASS Children and Young Person’s Outreach Support Worker – Jo Parsons

SDASS Young People’s and Adolescent’s Outreach Support Worker – Hannah Black

SDASS Children & Young People’s Outreach Service Manager – Charlotte Gibbon

Thanks for taking the time to complete this referral.

To submit your fully completed document, please email: [childsupport@swindonwomensaid.org](mailto:childsupport@swindonwomensaid.org)

**Before you send the referral, please ensure that your referral meets the criteria set out on the first page of this document.**

Please attach any other relevant documents that would support this referral.