

APPLICATION FOR REFERRAL FORM



Please Return this form to:
Aspire Support Services Ltd
145-157 St John Street,
London EC1V 4PW
 Or Email:
admin@aspire-supportservices.co.uk

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS AND BLACK INK ONLY.

Placing Organisation/Local Authority:	
Name of Referrer:	
Direct Telephone Number & Email Address:	

YOUNG PERSONS DETAILS

First Name:	
Surname:	
Gender:	
Date of Birth:	
Current Address:	
	Post Code:
Contact Telephone Number:	
Ethnicity:	
Religion:	
First Language:	
Speaks English:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Interpreter Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Previous Psychiatric History and Date of any Diagnosis	

OTHER CONTACTS

	Name	Address	Telephone No.
GP			
Social Worker			
Next of Kin			

REASONS FOR REFERRAL

Present Needs/Difficulties or Concerns

Pathway Plan/Care Plan Objectives (include priorities)

Risk Assessment (Socially Isolated, Struggling, Expressing Anxiety, Stress, Suicidal, etc.)

Relapse Indicators

Medication History

OTHER USEFUL INFORMATIONCourt Proceedings – Yes/No
(dates if applicable):

Bail Conditions:

Details of other services needed or in place:

SOCIAL SKILLS

Yes

No

Can relate appropriately to peers - Male

Can relate appropriately to peers - Female

Can relate appropriately to younger children

Can relate appropriately to older children

Can relate appropriately to adults

Can relate appropriately to care workers

Loner/Solitary

Likes animals/pets

Enjoys outdoor activities		
Has leisure interests/hobbies/skills		
Frustration/Aggression		
Manages frustration		
Temper tantrums		
Provokes conflict		
Verbally aggressive towards female care worker		
Verbally aggressive towards male care worker		
Verbally aggressive towards peers		
Physically aggressive towards female care worker		
Physically aggressive towards male care worker		
Physically aggressive towards peers		

Supervision Needs	Yes	No
Copes with rules/boundaries		
Can occupy self without supervision		
Attention seeking		
Goes missing from home		
Goes missing from placement		
Goes missing from school		

Safe Care	Yes	No
Has witnessed domestic violence		
Has been physically abused		
Has been sexually abused		
Is there a history of sexual abuse within the family?		
Could child have witnessed sexual abuse?		
Is a target for sexual abuse		
Displays sexualised behaviour?		
Has been emotionally abused		
Displays bullying behaviour		
Is a target for being bullied		
Displays inappropriate sexualised behaviour		

Any concerns with placing with another child?		
Self Harming Behaviour?		
Suicidal Tendencies?		

HEALTH NEEDS	Yes	No
Takes medication		
Any known allergies?		
Has special dietary needs		
Uses tobacco		
Uses alcohol		
Other		
Any history of mental health concerns		
Manages self care/personal hygiene		
Enuresis/Encopresis		
Travel sick		

NIGHT TIME ROUTINE	Yes	No
Used to a shared bedroom		
Used to sleeping alone		
Has difficulty settling		
Frequent night time disturbance/nightmares		
Has phobias/fears		
Uses medication to aid sleep		

OFFENDING BEHAVIOUR	Yes	No
Arson		
Assault		
Car-related crime		
Sexual assault		
Theft/Burglary/Shoplifting		
Criminal damage		

Signature of Referrer: _____ **Date:** _____