

Date:

Client Number:

Young Persons Details:

Name: _____ Date of Birth: _____
 Gender at birth: Male Female Identifies as: _____
 Address: _____ Town: _____
 Postcode: _____ Mobile: _____
 Education/Training/Employment Status: _____
 Name of setting: _____ Days/hours attending: _____
 The young person should consent to the referral before submitting. Consented : Yes No

Parent/Carer:

Name: _____
 Telephone: _____
 Email: _____
 Address: _____
 Postcode: _____
 Are they aware of this referral? YES NO

Parent/Carer:

Name: _____
 Telephone: _____
 Email: _____
 Address: _____
 Postcode: _____
 Are they aware of this referral? YES NO
 Are they aware of this referral?
 YES NO

Referrer: Self-Referral

Name: _____ Role: _____
 Telephone: _____ Email: _____
 Address: _____ Postcode: _____

Other Professionals/Agencies involved:

Name: _____
 Role: _____
 Telephone: _____
 Email: _____
 Address: _____

Name: _____
 Role: _____
 Telephone: _____
 Email: _____
 Address: _____

Name: _____
 Role: _____
 Telephone: _____
 Email: _____
 Address: _____

Name: _____
 Role: _____
 Telephone: _____
 Email: _____
 Address: _____

Accessing Family Support

Cared For Child Child in Need Child Protection Early Help

Please give details of lead professional and team around the family:

Drug/alcohol use: (substances used, amount/level of intoxication, frequency/duration of use)

Health: (physical, emotional, sexual, self-harm, suicidal ideation)

Education/Training/Employment: (attendance, exclusions)

Special Educational Needs & Disabilities Education Health & Care Plan Home Schooled

Relationships: (peer, family, romantic)

Behaviour: (safety, money, gambling, child exploitation, offending, anti-social behaviour, boundaries)

Any immediate safeguarding concerns:

Risk to others YES NO

Risk to self YES NO

Risk for lone working YES NO

Home visit warning YES NO

Submit completed form to: Matrixenquiries@southtyneside.gov.uk