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*Advocacy Service for Young People 11-25*

**Tel/Ffôn: 0800 0322 630**

***For office use only***

***Date referral received: Capita Number: Case number:***

***Advocate: Re-referral? Yes*** [ ]  ***No*** [ ]

***PLEASE NOTE REFERRAL FORMS WITHOUT A COMPLETED RISK ASSESSMENT WILL NOT BE ACCEPTED***

***PERSONAL DETAILS***

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | **Miss** [ ]  **Ms** [ ]  **Mrs** [ ]  **Mr** [ ]  | **Full Name** |  |
| **Address**  |  |
| **Postcode** |  | **DOB / Age**  |  |
| **Gender**  |  | **Pronouns** |  |
| **Mobile Number** |  | **Email** |  |
| **Parent / Guardian Name** | **Telephone Number** | **Email**  |
|  |  |  |
| **Does the young person have a social worker YES** [ ]  **NO** [ ]  |
| **Social Workers Name** | **Telephone Number** | **Email**  |
|  |  |  |
| **Appropriate Referral?**  | **YES** [ ]  **NO** [ ]  | **Name of Referrer** |  |
| **Relationship to referrer** |  | **Contact number of referrer** |  |
| **Young persons first language** |  | **STATUS****Is the young person in** | **Education** [ ]  **Employment** [ ]  **Training** [ ]  **NEET** [ ]  **Parent** [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Any disability?**  | **YES** [ ]  **NO** [ ]  | **If YES give details:** |  |
| **Has the young person agreed to the referral?**  | **YES** [ ]  **NO** [ ] **If not why? We cannot accept referral** | **Is the parent/guardian aware of the referral?** | **YES** [ ]  **NO** [ ]  **N/A** [ ] **If not why?** |

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| ***ADVERSE CHILDHOOD EXPERIENCES*** *Are there any of the following identified?* |
| **Physical abuse** [ ]  **Domestic Violence** [ ]  **Sexual abuse** [ ]  **Verbal abuse** [ ] **A family member who is depressed or diagnosed with a mental illness** [ ] **A family member who is addicted to alcohol or drugs** [ ]  **A family member who is in prison** [ ] **Losing a parent to separation divorce or death** [ ]  |

**Current / Previous Support Received (Are any other agencies involved with any members of the household?)**

*(If known) please detail any previous/other current housing-related support received.*

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| **Agency** | **Contact Name and number** | **Details of support provided (if known)** |
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| **Reason for referral:** |
|  **Risk Assessment**If it has been highlighted that there is a risk of harm to self, or risk to others or risk from others then please complete this form. **Please complete a separate form for each risk.**

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| --- | --- | --- |
|  **Type of risk present (not exhaustive):**  | **Yes** | **No** |
| ***Risk to self:*** suicidal thoughts, self-harm, suicide attempts, substance misuse, impulsivity, self-neglect, risky behaviour | [ ]  | [ ]  |
| ***Risk to others:*** aggressive / violent / sexually inappropriate / impulsive behaviour, history of false allegations, infection, issues re transporting,  | [ ]  | [ ]  |
| ***Risk from others:*** domestic abuse, honour based violence, sexual/ criminal exploitation, parental lack of concern/ supervision,  | [ ]  | [ ]  |

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| **Summary of Risk:** Please describe exactly what the risk is, who this risk is to and from, why this is a risk and triggers for related behaviour, where it is mostly likely to occur and at what times |
|  |
| **Controls already in place to try and reduce/manage the identified risks** |
|  |
| **Additional Actions/Controls needed to reduce/manage the risk *following* assessment:** |
|  |
| **If identified Risk/s become unmanageable state what action will need to be taken?** |
|  |
| **What key pieces of information need to be shared and with whom, following assessment?** |
|  |

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| --- | --- | --- | --- |
| **Referrers signature** |  | **Date** |  |

**For information as to how Wrexham County Borough Council handles personal data, please see our Privacy Notices on our website:** [**www.wrexham.gov.uk**](http://www.wrexham.gov.uk)**Please send completed referral forms marked ‘PRIVATE AND CONFIDENTIAL’ to:****Second Voice, Lambpit Street, Wrexham LL11 1AR****Tel: 01978 295600 Free phone: 0800 0322 630 Email:** **secondvoice@wrexham.gov.uk** |