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**DIGARTREF**

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| **WORKSHOP Referral Form** |





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| **REFERRING AGENCY DETAILS** |
| **Name of Referrer** |  |
| **Name of Agency** |  |
| **Address of Agency** |  |
| **Telephone Number** |  | **Mobile Number** |  |
| **Email Address** |  |
| **Date of Referral** |  |

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| **WORKSHOP** |
| **Please select which workshop(s) you are referring for:-** |
| [ ]  ECLIPS *(Parents of 3 – 10 year olds)*[ ]  ESCAPE *(Parents of 10 – 16 year olds)*[ ]  Seasons For Growth Adult | [ ]  Parallel Lines *(Young People 10 – 16 years old)*[ ]  Seasons For Growth Young People *(13 – 17 year olds)* |

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| **LEAD CLIENT DETAILS** |
| **Title** | [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other: \_\_\_\_\_\_\_\_ |
| **Full Name** |  |
| **Date of Birth** |  |
| **Address** |  | **Postcode** |  |
| **Mobile Number** |  | **Landline** **Number** |  |
| **Email Address** |  |
| **Preferred Method of Contact**  | [ ]  Call [ ]  Text [ ]  Letter [ ]  Email  | **Preferred Language** | [ ]  Welsh [ ]  English [ ]  Other \_\_\_\_\_\_\_\_\_\_ |
| **Form of Transport** | [ ]  Car [ ]  Bus [ ]  Train [ ]  Transport provided by a relative/friend |

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| **OTHER CLIENT PERSONAL DETAILS***(please include the details of any other relevant individuals you are referring)* |
| **Contact Details** |
| **Title** | [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other: \_\_\_\_\_\_\_\_ |
| **Full Name** |  |
| **Date of Birth** |  | **Relation to Lead Client** |  |
| **Address** |  | **Postcode** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Preferred Method of Contact**  | [ ]  Call [ ]  Text[ ]  Letter [ ]  Email  | **Preferred Language** | [ ]  Welsh [ ]  English [ ]  Other: \_\_\_\_\_\_\_\_\_ |

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| **Contact Details** |
| **Title** | [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other: \_\_\_\_\_\_\_\_ |
| **Full Name** |  |
| **Date of Birth** |  | **Relation to Lead Client** |  |
| **Address** |  | **Postcode** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Preferred Method of Contact**  | [ ]  Call [ ]  Text[ ]  Letter [ ]  Email  | **Preferred Language** | [ ]  Welsh [ ]  English [ ]  Other: \_\_\_\_\_\_\_\_\_ |

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| **Contact Details** |
| **Title** | [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other: \_\_\_\_\_\_\_\_ |
| **Full Name** |  |
| **Date of Birth** |  | **Relation to Lead Client** |  |
| **Address** |  | **Postcode** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Preferred Method of Contact**  | [ ]  Call [ ]  Text[ ]  Letter [ ]  Email  | **Preferred Language** | [ ]  Welsh [ ]  English [ ]  Other \_\_\_\_\_\_\_\_ |

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| **Other Significant Family Members***(within household, and/or who are significant to the family)* |
| **Name** | **D.O.B** | **Relationship** | **Telephone No.** | **Address** |
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| **REASON FOR REFERRAL** |
| **Brief outline/background of the support the referred family have previously received or currently receiving:** *(Examples: Agencies such as Local Authorities, TAF, YJS, CAHMS, Housing etc.)***What are the outcomes you/the family would like to achieve through attending our Workshop(s)?** *(Please state clearly which workshop each named client is referred for and the individual outcomes you would like to achieve as well as family outcomes, such as: Relationship, Understanding, Behaviour, Communication)* |

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| **OFFENDING BEHAVIOUR** |
| **Has any named person on this referral ever had any convictions, cautions or warnings?**[ ]  Yes *(if yes, please specify below)* [ ]  No [ ]  UnknownName of Client:Offending Behaviour: Date Occurred: Triggers: Outcome:  |

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| **RISK ASSESSMENT***(please tick the risks related to any named person on this referral)* |
| **Risk** | **Level of Risk***(if there are no risks, please tick “none”)* | **Type** | **Details***(client name, triggers, dates, support)* |
| [ ]  Abuse | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan | [ ]  Physical[ ]  Sexual[ ]  Verbal[ ]  Other: \_\_\_\_\_\_\_\_ |  |
| [ ]  Subsance Misuse | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan | [ ]  Drugs[ ]  Alcohol[ ]  Other: \_\_\_\_\_\_\_\_ |  |
| [ ]  Self-Harm / Suicidal Thoughts | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan | [ ]  Overdose[ ]  Cutting[ ]  Thoughts Only[ ] Other: \_\_\_\_\_\_\_ |  |
| **Risk** | **Level of Risk** | **Diagnosis** | **Prescribed Medication** |
| [ ]  Mental Health*(Examples: Depression, Anxiety, Personality Disorder, PTSD)* | [ ]  Low[ ]  Stable[ ]  High[ ]  Safety Plan |  | [ ]  Yes [ ]  No[ ]  Not Known |
| [ ]  Medical Condition*(Examples: Diabetes, Asthma, Heart Condition, ADHD)* | [ ]  Low[ ]  Stable[ ]  High[ ]  Safety Plan |  | [ ] Yes [ ]  No[ ]  Not Known |
| **Risk** | **Level of Risk** | **Details of Risk***(please note client name and* *give details of the risk)* |
| [ ]  Isolation | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan |  |
| [ ]  Sexual Exploitation | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan |  |
| [ ]  Financial Exploitation | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan |  |
| [ ]  Arson | [ ]  None[ ]  Historical[ ]  Current Risk[ ]  Safety Plan |  |

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| **RISK TO STAFF / OTHERS***(please tick the risks related to any named person on this referral)* |
| **Risk** | **Level of Risk** | **Type** | **Details***(please note client name, triggers and safety plan)* |
| [ ]  Abuse | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious | [ ]  Physical[ ]  Sexual[ ]  Verbal[ ]  Other: \_\_\_\_\_\_\_\_\_\_ |  |
| [ ]  Assault | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious | [ ]  Physical[ ]  Sexual[ ]  Other: \_\_\_\_\_\_\_\_\_\_ |  |
| **Risk** | **Level of Risk** | **Details of Risk***(please note client name and* *give details of the risk)* |
| [ ]  Mood Swings | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |
| [ ]  Infectious Disease | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |
| [ ]  Working in Groups | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |
| [ ]  Risk to Children | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |
| [ ]  Risk to Sharps | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |
| [ ]  Risk of Arson | [ ]  None[ ]  Needs Awareness[ ]  Risk Plan[ ]  Very Serious |  |

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| **DETAILS OF OTHER AGENCIES INVOLVED** |

**Please give the full details of all agencies currently involved with the client/family:**

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| **Name of Organisation** | **Contact Name** | **Address**  | **Contact Number**  | **Email** |
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**Digartref accepts referrals to our services, and ensures no person receives less favourable treatment on the grounds of gender, sexual orientation, disability, race, religious belief, age or any other grounds.**

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| **Signed by Referral Agency:** |  |
| **Print Name:**  |  |
| **Date:** |  |

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| **Client Signature** *(if possible)***:** |  |
| **Print Name:**  |  |
| **Date:** |  |

**Please e-mail this referral to:** mediation@digartref.co.uk

**Or post to:** Digartref, Unit 3, Enterprise Centre, Holyhead, Anglesey LL65 2HY

If you have any enquiries, please call us on: 01407 761653