**A picture containing clipart

Description automatically generated**

**DIGARTREF**

|  |
| --- |
| **WORKSHOP Referral Form** |

A picture containing text, clipart

Description automatically generated

A picture containing text, clipart

Description automatically generatedA picture containing text, clipart

Description automatically generated

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

|  |  |
| --- | --- |
| **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)* |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 \_\_\_\_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Other Significant Family Members**  *(within household, and/or who are significant to the family)* | | | | |
| **Name** | **D.O.B** | **Relationship** | **Telephone No.** | **Address** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **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)* |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  | |

|  |
| --- |
| **DETAILS OF OTHER AGENCIES INVOLVED** |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Organisation** | **Contact Name** | **Address** | **Contact Number** | **Email** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**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.**

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

|  |  |
| --- | --- |
| **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