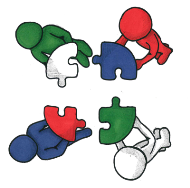
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**DIGARTREF**

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| **Mediation & Family Intervention**  **Referral Form** |

***We reserve the right to decline any referral that does not meet our criteria, and every referral will be assessed on an individual basis. If your referral is not successful in meeting our criteria, we will inform you via email or letter.***

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

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| **PERSONAL LEAD CLIENT DETAILS** |

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| Title:  First Name:  Middle Name(s):  Surname:  Preferred Name: | Mr  Mrs  Miss  Ms  Dr  Other: \_\_\_\_\_\_\_\_ | Marital Status: | Single  In Relationship  Married  Divorced  Widowed  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mobile Number:  Landline  Number:  **\*Email\*:**  *(needed to engage online)*  Preferred Method of Contact:  Preferred Language: |  |
| Date of Birth: |  |
| Address:  Post Code: |  |
| Form of Transport: | Car  Bus  Train  Transport provided by a relative/friend | | |

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| **OTHER CLIENT DETAILS**  *(please include any other relevant individuals you are referring)* | | | | | | |
| **Contact Details** | | **Relationship to Lead Contact:**  **Parent  Child  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Title** | |  | | | | |
| **Full Name** | |  | | | | |
| **Date of Birth** | |  | | | | |
| **Address** | |  | | | | |
| **Telephone Number** | |  | | | | |
| **Preferred Language** | |  | | | | |
| **Aware of Referral made?** | | Yes  No *(we strongly suggest that all parties are made aware of this referral before submission to avoid any misunderstanding)* | | | | |
| **Contact Details** | | **Relationship to Lead Contact:**  **Parent  Child  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Title** | |  | | | | |
| **Full Name** | |  | | | | |
| **Date of Birth** | |  | | | | |
| **Address** | |  | | | | |
| **Telephone Number** | |  | | | | |
| **Preferred Language** | |  | | | | |
| **Aware of Referral made?** | | Yes  No *(we strongly suggest that all parties are made aware of this referral before submission to avoid any misunderstanding)* | | | | |
| **Contact Details** | | **Relationship to Lead Contact:**  **Parent  Child  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Title** | |  | | | | |
| **Full Name** | |  | | | | |
| **Date of Birth** | |  | | | | |
| **Address** | |  | | | | |
| **Telephone Number** | |  | | | | |
| **Preferred Language** | |  | | | | |
| **Aware of Referral Made?** | | Yes  No *(we strongly suggest that all parties are made aware of this referral before submission to avoid any misunderstanding)* | | | | |
| **Other Significant Family Members** | | | | | | |
| **Name** | **D.O.B** | | **Relationship** | | **Telephone No.** | **Address** |
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| **TYPE OF REFERRAL** | | | | | | |
| **Intervention / Workshop** *(please tick)***:**  ESCAPE (Parenting Workshop)  Parallel Lines (Young People Workshop)  Seasons For Growth (Adult)  Seasons For Growth (Child) | | | | **Mediation** *(please tick)***:**  Family Mediation  Neighbourhood Mediation  Tenant Landlord Mediation  Supported Accommodation Mediation | | |
| **FAMILY PROFILE** | | | | | | |
| **Brief outline of the support the family have previously received or currently receiving from your Agency, or other Agencies:**  **What are the outcomes you would like to achieve?** *(Examples: Relationship, Understanding, Behaviour)*  **Please explain any risks involved in supporting the family, and recommended measures to reduce risk:** (*Example: Lone Working (2:1), Housing Conditions, Animals)* | | | | | | |

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| **OFFENDING BEHAVIOUR** |
| **Has any named person on this referral ever had any convictions, cautions or warnings?**  Name of Client:  Offending Behaviour:  Date Occurred:  Triggers:  Outcome: |

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| **RISK TO CLIENT**  *(please tick the risks 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: \_\_\_\_\_\_\_\_ |  |
| Subsance Misuse | None  Needs Awareness  Risk Plan  Very Serious | Drugs  Alcohol  Other: \_\_\_\_\_\_\_\_ |  |
| Self-Harm / Suicidal Thoughts | None  Needs Awareness  Risk Plan  Very Serious | Overdose  Cutting  Thoughts Only  Other: \_\_\_\_\_\_\_\_\_ |  |
| **Risk** | **Level of Risk** | **Diagnosis** | **Prescribed Medication** |
| Mental Health  *(Examples: Depression, Anxiety, Personality Disorder, PTSD)* | None  Needs Awareness  Risk Plan  Very Serious |  | Yes  No  Not Known |
| Medical Condition  *(Examples: Diabetes, Asthma, Heart Condition, ADHD)* | None  Needs Awareness  Risk Plan  Very Serious |  | Yes  No  Not Known |
| **Risk** | **Level of Risk** | **Details of Risk**  *(please note client name and*  *give details of the risk)* | |
| Isolation | None  Needs Awareness  Risk Plan  Very Serious |  | |
| Sexual Exploitation | None  Needs Awareness  Risk Plan  Very Serious |  | |
| Financial Exploitation | None  Needs Awareness  Risk Plan  Very Serious |  | |
| Arson | None  Needs Awareness  Risk Plan  Very Serious |  | |

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| **RISK TO STAFF / OTHERS**  *(please tick the risks 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