**Referral Form for Positive Relationship Programme**



\*\***ALL SECTIONS OF THE FORM NEED TO BE COMPLETED IN DETAIL\*\***

**The information on this form remains confidential to KDAC unless child protection or police issues arise where we are obliged to forward relevant information only**

**Criteria for girls aged 11-15 years**

(Please tick):

|  |  |
| --- | --- |
| * Looked after children and children in need (age 11-15) * Girls aged 11- 15 excluded and missing from education * Girls aged 11-15 with a conduct disorder and low attainment * Girls who are already parents and/or have experienced domestic abuse | * Girls who have learning disabilities and are in mainstream education * Girls who have siblings that are teenage parents and/or who have entered into coercive and violent relationships * Girls who have witnessed or experienced domestic abuse within the family home |

**Office Use Only**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Referral |  | | | Rec’d | | | | Start date | Completion date | | | Criteria met  Y/N | |
| Referring agency |  | | | | | | | | | | | | |
| Contact name: | | | | | | | Contact role: | | | | | | |
| Contact number: | | | | | | | Contact email: | | | | | | |
| Name of young person: | | | | | | | DOB: | | | | | | Age: |
| Name of parent/carer | | | | | | | DOB: | | | | | | Age: |
| Address: | | | | | | | Permission to write? | | | | | | |
| Home phone number: | | Permission to phone | | | Permission to leave a message | | | | | | | | |
| Mobile Number: | | Permission to phone | | | Permission to leave a message | | | | | | | | |
| Is the child/young person currently living with abuse? | | | | | | | Y | | | | N | | |
| Other agencies currently/previously involved: | | | | | | | Reason for involvement: | | | | | | |
| Assessments:  CAF YES/NO Date: CP Plan YES/NO Date:  MARAC YES/NO Date: CHIN YES/NO Date:  STATEMENTED YES/NO Date: CAMHS YES/NO Date: | | | | | | | | | | | | | |
| Reason for referral (including any other details you feel are relevant, use separate sheet if necessary): | | | | | | | | | | | | | |
| Ethnicity....................................................... Disability/ learning disability YES/NO | | | | | | | | | | | | | |
| School of referred young person: | | | Address: | | | Contact name:  Same as above | | | | Contact telephone number:  Same as above | | | |
| Does Young Person consent to referral? | | | | | | Yes | | | |  | | | |
| Parental/Carer permission provided to referrer: | | | | | | Yes | | | |  | | | |

**Return To: Block G, Chaucer Technology School, Spring Lane, Canterbury CT1 1SU.**

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