**Off Centre at Family Action**

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| REFERRAL FORM: \*Young people must be 16-25yrs old and be registered with a City & Hackney GP to access Off Centre\* | | | | | | | | | | | | | | | | |
| **Young Person Name:** | | |  | | | | **Surname:** | | | |  | | | | | |
| **Date of Birth:** | | |  | | | | **Age:** | |  | | **GP Surgery:** |  | | | | |
| **Gender:** MaleFemale  Non-Binary  Other  Please state: | | | | | | | **Do you identify as trans?**  Yes  No  Not sure  Prefer not to say | | | | | | | | | |
| **Nationality:** | | |  | | | | **Religion/Belief:** | | | |  | | | | | |
| **Ethnicity:** | | |  | | | | | | | | | | | | | |
| **Sexuality:** | | | Heterosexual (straight)Bisexual  Gay or Lesbian  Not sure  Prefer not to say  Other  Please state: | | | | | | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | **Postcode:** | | |  |
| **Living situation:** | | | e.g. in hostel, with family, with friends, homeless | | | | | | | | | | | | | |
| **Contact number:** | | |  | | | | **Email address:** | | | |  | | | | | |
| **Is it okay to receive texts / voicemails / emails?**  Yes  No  if no, please give further details: | | | | | | | | | | | | | | | | |
| **School / College / Occupation:** | | | | In education  In employment  Not in education or employment  Name of education establishment: | | | | | | | | | | | | |
| **Name of person(s) with parental responsibility: (\*If YP under 18):** | | | | | | | | | | |  | | | | | |
| **Main Carer(s):** Mother  Father  Grandparent  Step Parent  Guardian/Other  Foster Parent  Resident Key Worker | | | | | | | | | | | | | | | | |
| **Do you have any children?** YesNoIf yes, please give name of child(ren) and date(s) of birth: | | | | | | | | | | | | | | | | |
| **Name of family members/household** | | | | | **D.O.B age** | | | **Relationship to the young person** | | | **Address if different** | | | | | |
|  | | | | |  | | |  | | |  | | | | | |
| Do you have any access needs due to Disability or Health? | | | | | YesNo Please state: | | | | | | | | | | | |
| Do you consider yourself to have a learning disability? | | | | | YesNo Please state: | | | | | | | | | | | |
| Do you consider yourself to have any developmental or medical conditions? | | | | | YesNo Please state: | | | | | | | | | | | |
| Do you have any physical conditions or allergies that we should know about? | | | | | YesNo Please state: | | | | | | | | | | | |
| SUPPORT REQUESTED: | | | | | | | | | | | | | | | | |
| Therapy – counselling / art therapy  Advice & Information  Keyworking  Project Indigo (LGBTQI+) | | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL:** | | | | | | | | | | | | | | | | |
| Please give us some information about what you (or the young person if you are making a referral on someone’s behalf) have come to Off Centre about e.g. what do you need help with, what are your main concerns, how are your issues impacting on you? Anything else you think we should know about you or your situation? | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| **SAFEGUARDING ISSUES OR ANY RELEVANT HISTORY OF TREATMENT INFORMATION:** | | | | | | | | | | | | | | | | |
| Are you involved with any other services e.g. Social Care, CAMHS, Adult Mental Health Services, Young Hackney etc? | | | | | | YesNo Please state: | | | | | | | | | | |
| Please give the name and contact details of all other professionals involved in supporting you: | | | | | |  | | | | | | | | | | |
| Are you or have you been in care or have you been accommodated by social services? | | | | | | YesNo Please state (include name of social worker): | | | | | | | | | | |
| Have you had any previous counselling or therapy? | | | | | | YesNo Please state: | | | | | | | | | | |
| How did you hear about Off Centre? | | | | | |  | | | | | | | | | | |
| **Consent:** | | | | | | | | | | | | | | | | |
| **If you are the young person:**  I consent to Family Action:   * Processing and storing my information given on the form in accordance with The Data Protection Act 2018 and   General Data Protection Regulation 2016/679 (GDPR).   * Processing and storing the personal data I have provided and any supporting information that is required.   If my referral is accepted, Family Action can:   * Seek information from other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals. * Share information with other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals in order to support my needs.   \*Please note that if you do not consent, we will continue to offer you our support, but the services provided to you may be affected. You can discuss this with your allocated Off Centre staff member, and if you have any further queries, with a member of Off Centre Management Team on the details below. | | | | | | | | | | | | | | | | |
| Name (YP): |  | | | | | | | Signed (YP): | |  | | | | Date: |  | |
| **If you are not the young person:**  Has the young person (or parent/carer if under 18) given consent for this referral to be made? Yes  No | | | | | | | | | | | | | | | | |
| **REFERRED BY:** | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | Designation / role: | | |  | | | | | |
| Signed: | |  | | | | | | Date of referral: | | |  | | | | | |
| Contact number: | |  | | | | | | Email address: | | |  | | | | | |

Please hand this form into reception at Off Centre or scan and email to [**OffCentre@family-action.org.uk**](mailto:OffCentre@family-action.org.uk)

Off Centre at Family Action – Unit 7 The Textile Building, 29a-31a Chatham Place, London E9 6FJ (entrance on Belsham Street)