Children’s Trauma Therapy Service - Referral Form



**About us**

The Children’s Trauma Therapy Service, at Bradford Family Action, is a specialist therapy service providing trauma and attachment focussed therapy for children and their families. We currently have two streams of therapy:

1. Specialist recovery-focussed therapy for children / young people aged 5-18 who have experienced sexual abuse or a traumatic bereavement. Our offer of therapy usually includes work with the whole family, though we also welcome self-referrals from individual young people.
2. Children aged 4-11 who have experienced one or more Adverse Childhood Experiences (ACEs) and who are experiencing trauma symptoms or family difficulties. These families can now receive therapy through CALM; a new therapy service jointly funded by the Department of Health and Bradford CCG. This service is led by the Children’s Trauma Therapy Service team and delivered in partnership with Step2 and Relate Bradford.

This referral form is primarily intended for professionals to complete on behalf of families they are working with.

However we also really welcome self-referrals from parents/carers and young people too. If you are a parent or young person and would like to refer yourself for therapy, please just give us a call on: **01274 651652** and ask for a member of the Children’s Trauma Therapy Service.

or email CTTS@family-action.org.uk

More information on the therapy streams we provide and who we work with is detailed in the document ‘Information about Referring to the Children’s Trauma Therapy Service’. Please use this form to clearly identify which therapy stream you are requesting.

Please send completed referral forms**:**

By secure email to CTTS@family-action.org.uk

Secure emails can be received through at this address through GalaxyKey, Egress Switch & by encrypted email.

Or by post to Children’s Trauma Therapy Service

Kenburgh House

28 Manor Row

Bradford, BD1 4QU

Please specify which service you wish to refer into:

Therapy Stream 1: Childhood Sexual Abuse Therapy Service ☐ Traumatic Bereavement Therapy Service: ☐

Therapy Stream 2: CALM (Adverse Childhood Experiences) service ☐

For CALM referrals, which of our service criteria is relevant to the child(ren)’s experience? Please tick all that apply

Neglect – Emotional: [ ]

Adult with Substance Abuse Problems: [ ]

Domestic Abuse: [ ]

Emotional Abuse: [ ]

Physical Abuse: [ ]

Neglect – Physical: [ ]

Parent Separation/Divorce: [ ]

Parent with a Mental Health Condition: [ ]

Household Member in Prison: [ ]

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| Referrers Details |
| Referrer’s Name and Agency: |  | Address (include Postcode): |  |
| Job Title: |  | Email:Mobile number: |  |
| What is your involvement with the child/family being referred? |  |
| What on-going contact will you have with the child/family being referred? |  |

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| Family Details |
| Name of Child(ren) or Young Person\*: \*If this referral is for more than one child in the family, please detail them all in the box below |  |
| Name of Parent/Carer: |  | Is an interpreter needed? Y/NIf yes, which language? |
| Address :(include Postcode) |  |
| Parent /Carer Email: |  | Can we leave a voicemail message? Y/NCan we send a text message? Y/N |
| Parent /Carer Phone Number: |  |
| Is this a self-referral by a young person or parent? | Y/N |  |
| **Young Person’s phone number\***\*Where possible. it is helpful to have this information for referrals of young people over the age of 13 |  | **Can we leave a voicemail message? Y/N****Can we send a text message? Y/N** |
| Young Person’s email address\* \*Where possible. it is helpful to have this information for referrals of young people over the age of 13 |  |  |

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| Family Details - continued |
|  | FIRST NAME | SURNAME | D.O.B | RELATIONSHIP IN FAMILY | GENDER | ETHNICITY | LANGUAGES SPOKEN | RELIGION | DISABILITY/ MEDICAL | SCHOOL  |
| CHILD(REN) or YOUNG PERSON BEING REFERRED\*\*Please list all children in the family that are being referred |  |  |  |  |  |  |  |  |  |  |
| ALL OTHER HOUSEHOLD MEMBERS |  |  |  |  |  |  |  |  |  |  |
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| Please give details of anyone not listed above who has significant caring responsibilities for the child: |
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| If the referred child /children reside at more than one address, please give details: |
|  |
| Does the child /children have a Statement of SEN/EHCP? if yes please give details: |
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| Information in support of the referral |
| Can you tell us what has happened to the child / children and family: when and who was involved? Please provide as much detail as possible: For sexual abuse referrals: please be specific regarding the nature of alleged sexual abuse. Please also provide details of any current investigations or criminal proceedings. |
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| How has this affected the child /children and family? What symptoms of trauma or attachment difficulties is the child or young person is displaying? What impact have these experiences had on their family relationships? |
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| What do you hope will change for the child/family being referred as a result of our involvement? |
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| Are there any barriers to this child/family accessing our service?  |
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| Why are you making the referral now? |
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| Safeguarding |
| Is there a current Risk Assessment?  | Yes / No | Has the parent/ carer given you consent to share this information with us | Yes / No |
| Is there a current Needs Assessment?  | Yes / No | Is the child a Looked After or Adopted Child (LAAC)? | Yes / No |
| Is the child/young person a Young Carer? | Yes / No | Does the Parent/Carer have a Care Programme Approach (CPA) Plan? | Yes / No |
| **Please note:** if the child is currently on a Child in Need of Child Protection Plan, LAAC or under an SGO, we will require a copy of the most recent Child and Family Assessment and/or care plan in this case. A copy of the relevant report should be sent with the referral. |
| Are there any children in the family who are currently, on the Children in Need or Child Protection Register? Please give details of any current Child in Need or Child Protection Registration with dates: | Yes / No |
| Name of child / children | Details of Registration | Start date / Expected end date |
|  |  |  **/** |
|  |  |  **/** |
| Are there any children in the family subject to court orders? If yes, please give details:(E.g. Residency order / Special Guardianship order / Prohibited steps / Non-Molestation order / Court order contact) | Yes / No |
| Name of child / children | Details of Registration | Start date / Expected end date |
|  |  |  **/** |
|  |  |  **/** |
|  |  |  **/** |
| Are there any ongoing criminal investigations or legal proceedings affecting this family? If yes, please give details:(E.g. Custody / Contact arrangements or CSA cases being investigated / proceeding to trial) | Yes / No |
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| Has this child been referred to any other therapeutic services?If they have also been referred to CAMHS, or are awaiting an assessment through CAMHS or other specialist service, please detail this below: |
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As a service we take a systemic approach to meeting the needs of the families we work with. That means that we would always try and build on the help and support available to them. In order to be as effective as possible it is really important that where possible we can contact other professionals. Please provide details of these agencies below if known:

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| All agencies currently involved with family |
| Role / Occupation | Name | Organisation and Contact Tel No | What is the involvement? | Do we have consent to contact them? |
| GP (Required) |  | **Email:** **Tel:**  |  | **Yes / No** |
| School(Required) |  | **Email:** **Tel:**  |  | **Yes / No** |
| Social Worker(Required if CiN /CP and Social worker is not the referrer) |  | **Email:** **Tel:**  |  | **Yes / No** |
| CAMHS(Required if already under their care) |  | **Email:** **Tel:**  |  | **Yes / No** |
| Police(The details of the Police Officer in Charge if the case (OIC) is needed if there is an active CSA or DA investigation / prosecution at the time of referral) |  | **Email:** **Tel:** |  | **Yes / No** |
| Other |  | **Email****Tel::** |  | **Yes / No** |
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