** Off Centre at Family Action **

**Professionals Referral Form**

Off Centre is not a crisis service

If a young person is in crisis please contact City and Hackney Mental Health Crisis line on 0800 073 0006 or the Samaritans on 116 123.

In an emergency please call 999 or attend the nearest A&E department.

Please read Off Centre Inclusion and Exclusion Criteria before making a referral.

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| PROFESSIONALS REFERRAL FORM: \*Young people must be 16-25yrs old and be registered with a City & Hackney GP to access Off Centre\* |
| **Young Persons Name:** |  | **Surname:** |  |
| **GP surgery:** |   | **Age:**  |  | **Date of Birth:** |  |
| **NHS number:**  |  |
| **Gender:** Male[ ] Female [ ]  Non-Binary [ ]   Other [ ]  Please state: | **Do they identify as trans?**Yes [ ]  No [ ]  Not sure [ ]  Prefer not to say [ ]  |
| **Pronouns:** |  | **Religion / Belief:**  |  |
| **Ethnicity:** |  | **Nationality:** |  |
| **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, 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 [ ]  |
| **Does the young person have any children?** Yes **[ ]** No **[ ]** If yes, please give name of child(ren) and date(s) of birth: |
| Are they pregnant?  | Yes **[ ]** No **[ ]**  Please state: |
| Do they have a learning disability? | Yes **[ ]** No **[ ]**  Please state: |
| Do they consider themselves to have any developmental, medical or physical conditions?  | Yes **[ ]** No **[ ]**  Please state:If yes do they have any access needs? |
| AREAS OF SUPPORT (PLEASE TICK AS MANY THAT APPLY) |
| Low mood [ ]  Anxiety [ ]  Identity [ ]  Relationships [ ]  Trauma [ ]  Substance or alcohol misuse/dependency [ ]  Eating Issues [ ]  Abuse [ ]  Other [ ]   |
| **SUPPORT REQUESTED:** |
|  Talking Therapy [ ]  Creative arts Therapy [ ]  Advice & Information/Keyworking [ ]  Project Indigo (LGBTIQ+) [ ]  Unsure and would like to hear more **[ ]**  |
| **OVERVIEW OF SUPPORT**  |
| Why is the young person seeking therapy? Please provide as much information as possible, including any assessments that you may have already completed  |
|  |
| **OVERVIEW OF RISK**  |
| Please provide any past or present risk associated with the young person |
| Suicidal ideation [ ] Suicidal plan/intent [ ] Previous suicide attempt/s  | Current self-harm [ ] History of self-harm [ ] Substance/alcohol abuse [ ] [ ]  | Forensic History [ ] Current risk to others [ ] Previous risk to others[ ]  | Domestic violence risks [ ] Safeguarding Risks [ ]  Children [ ]  Adults [ ]  |
| Please detail the history of risk and any other concerns that you may have: *(Including dates, method, attendance at hospital etc.)* |
|  |
| **OTHER SERVICES THAT SUPPORT THE YOUNG PERSON**  |
| Is the young person currently receiving / have they received support from any of the following services?  | **Currently:** Social Care [ ]  CAMHS [ ]  Adult Mental Health/Secondary Care Service [ ]  Neighbourhoods team [ ]  Specialist Psychotherapy Service [ ]  IAPT / Talk Changes [ ]  Young Hackney [ ]  Private Therapy [ ]  None [ ]  Other [ ]  (if other please detail)………………… | **In the past:**Social Care [ ]  CAMHS [ ]  Adult Mental Health/Secondary Care Service [ ]  Neighbourhoods team [ ]  Specialist Psychotherapy Service [ ]  IAPT / Talk Changes [ ]  Young Hackney [ ]  Private Therapy [ ]  None [ ]  Other [ ]  (if other please detail)………………… |
| If the young person is involved with other services for their emotional or mental health wellbeing please provide contact details here:  |  |
| Please give details of current interventions/therapy: |  |
| Does the young person consent to this referral?  |  Yes **[ ]** [ ]  No**[ ]** [ ]  |
| Does the young person consent to Off-Centre contacting services they are involved in? | Yes [ ]  No [ ]  Not yet [ ]   |
| Has the young person been in care or been involved with social care either in the past or currently?  | Yes **[ ]** No **[ ]**  Please state (include name of social worker): |
| **Referer details** |
| Name of referrer |  | Organisation |  | Phone number |  |
| Role/Job Title |  | Email address |  | Date |  |

Please hand this form into reception at Off Centre or email to **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)