** 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:** MaleFemale  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?** YesNoIf yes, please give name of child(ren) and date(s) of birth: | | | | | | | | | | | | | | | | |
| Are they pregnant? | | | | | YesNo Please state: | | | | | | | | | | | |
| Do they have a learning disability? | | | | | YesNo Please state: | | | | | | | | | | | |
| Do they consider themselves to have any developmental, medical or physical conditions? | | | | | YesNo 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? | | | | | | YesNo 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**](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)