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| **consent Statement** |
| **Please note by completing this Request for Support, Compass expects that:**   * this referral has been discussed and agreed by the young person (if aged 16 years and over); * for children under 16 years or young people who lack capacity to consent the parent/carer has agreed to referral; * you have explained that any information held on this form will be stored by Compass on a secure database; * by making this request, you understand that information provided to our service will be stored securely electronically, and may be shared between other agencies including Child and Adolescents Mental Health Services (CAMHS), Schools Mental Health in Schools Team (MHST), GP and any other agency where it is necessary to safeguard the young person or provide the young person with appropriate support.   Signed by referrer: ………………………………………………….. Date: ……………………………………………………..  Signed by parent/carer:………………..…………………….. Signed by young person:………………………………………………..  **How did you hear about our service?** E.g. directed by, GP; School Nursing; School; an organisation; MHST; other professional.  …………………………………………………………………………………………………………………………………………………………………….. |

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| **Compass** **Shine’s** Children and Young People’s Emotional Health and Wellbeing Service offers support to Children, Young People and Families (CYPF), providing short term, typically 6 – 8 sessions, to CYPF up to 18 years of age, who experience **mild to moderate** emotional health difficulties. We also provide this support to young adults up to 25 years, with additional Special Education Needs (SEN), and Care Leavers, who may benefit from brief intervention.  **Compass** **Shine’s** primary offer of support is **small, focussed workshops/groups (max 7-8 people)**, in-person or remote. We also have a digital intervention, called Silver Cloud, and can give advice, and signpost. If we consider there to be additional need following access to workshop support, one of the practitioners will offer this. We will also consider this at the Assessment stage, to ensure the right support is accessed.  **PLEASE** ensure you complete all sections of this form as this helps us to ensure the right support is received.  Thank you.  To ensure the CYPF receive the right support at the right time by the right professional, we need you to consider the following inclusion and exclusion criteria:  **Inclusion**  Compass Shine Coventry **can** support children and young people with - please state which number applies the most -   1. Emerging low mood: sadness, low motivation (but willing to engage); 2. Difficulty managing emotion; 3. Mild to moderate anxiety: worries, irrational fears and concerns; 4. Emerging behaviours that challenge, causing distress; 5. Family and peer relationship difficulties; 6. Difficulty adjusting to change and transition.   **Exclusion**  Compass Shine Coventry **cannot** work with children and young people who:   * Are currently referred to any other emotional-wellbeing service (within the school or externally); * Have a formal mental health diagnosis with a severe presentation; * Have long term self-harming behaviours; * Have persistent/intrusive suicidal thoughts/intent and plan to act; * Are in crisis or requiring out of hours support – phone 111, and press 2; * Have a moderate to severe learning disability; * Are requiring long-term therapy (8 weeks plus).   **PLEASE NOTE**: If you are unsure whether a child or young person would benefit from support from Compass Coventry, please call the Team on 024 7518 6206 (Monday – Thursday 9a.m. - 4.30p.m. & Friday 9a.m. – 4p.m.)  ***Please note that it may hold up the referral if Compass is unable to speak with the referrer following this Request for Support*** | | | | | |
| **CONTACT DETAILS OF REFERRER** | | | | | |
| **Name:** | | | **Relationship to child/young person/family:** | | |
| **Organisation (if applicable):** | | | | | |
| **Address:** | | | | | |
| **Referrer’s contact phone number:** | | | | | |
| **Referrer’s email address:** | | | | | |
| **Has the young person consented to this request for support?** Yes  No | | | | | |
| **Has the young person’s parent/carer (if under 16) consented to this request for support?** Yes  No | | | | | |
| **Has the young person consented to being contacted via text message?** Yes  No | | | | | |
| **Has the parent/carer consented to being contacted via text message?** Yes  No | | | | | |
| **CONTACT DETAILS OF THE CHILD OR YOUNG PERSON** | | | | | |
| **Child/young person’s full name:** | | | | **Preferred name:** | |
| **Please give names of siblings:** | | | | **Also referring in? Yes / No**  **If so who:** | |
| **Is your gender different to the one assigned to you at birth? Yes / No** | | | | **Preferred pronoun:** | |
| **Child/young person’s address:** | | | | | |
| (*N.B. we may correspond by post unless referrer explicitly instructs us not to.)* **Postcode:** | | | | | |
| **Child/young person’s mobile phone number:**  (*N.B. we may leave a message on this phone number unless referrer explicitly instructs us not to.)* | | | | | |
| **Child/young person’s landline phone number:**  (*N.B. we may leave a message on this phone number unless referrer explicitly instructs us not to.)* | | | | | |
| **Child/young person’s date of birth:** | | | | **Age:** | |
| **Child/young person’s gender:** | | | | **Religion:** | |
| **Ethnicity:** | White  Mixed  Asian or Asian British  Black or Black British  Other Ethnic Groups  Not known | | | **Main Language:**  (Is an interpreter required? If so specify language.) | Documents required in main language |
| **Next of Kin:** | | | | | |
| **Accommodation status:**  (i.e. living with parents, living with relatives, fostered, adopted, living independently.) | | | | | |
| **Are there any methods by which the child/young person does NOT want to be contacted?** | | | | | |
| **CONTACT DETAILS OF PARENT / CARER** | | | | | |
|  | | **Parent One** | | **Parent Two** | |
| **Parent/Carer’s Name:** | |  | |  | |
| **Relationship:** | |  | |  | |
| **Parent/ Carer’s Address:** | | (N.B. we may correspond by post unless | | referrer explicitly instructs us not to.) | |
| **Parent/carer’s contact phone number:** | | (N.B. we may leave a message on this phone | | number unless instructed not to.) | |
| **Parent/carer’s email address:** | | (N.B. we may correspond by email unless | | referrer instructs us not to.) | |
| **Main language:** | |  | |  | |
| **Is an interpreter required?** | |  | |  | |
| **SCHOOL/COLLEGE DETAILS (if applicable)** | | | | | |
| **Name of the school the young person attends:** | | | | | |
| **Is this an MHST school? (Supported by Mental Health in Schools Team) YES / NO** | | | | | |
| **Year group:** | | | | | |
| **Name of key contact / member of staff at school:** | | | | | |
| **Telephone number of the school:** | | | | | |
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| **GP DETAILS** | | | | | |
| **G.P name:** | | | | | |
| **Name and address of G.P surgery:** | | | | | |
| **Phone number:** | | | | | |
| **Email address:** | | | | | |
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| **Do any of the below apply to this young person?** | | | | | |
| Subject to a Child Protection Plan (CP) / Child in Need Plan (CiN) | | | | Yes  No  Don’t know | |
| Elected Home Educated | | | | Yes  No  Don’t know | |
| Child Looked After (CLA) | | | | Yes  No  Don’t know | |
| Young Carer | | | | Yes  No  Don’t know | |
| Care Leaver | | | | Yes  No  Don’t know | |
| Excluded / at risk of exclusion | | | | Yes  No  Don’t know | |
| Substance misuse | | | | Yes  No  Don’t know | |
| Not in Education or Employment or Training (NEET) | | | | Yes  No  Don’t know | |
| Special Educational Need or Disability (SEND) | | | | Yes  No  Don’t know | |
| Neurodiverse Diagnosis (e.g. ASD, ADHD) or awaiting | | | | Yes  No  Don’t know | |
| Education Health and Care Plan (EHCP) | | | | Yes  No  Don’t know | |
| Physical health needs (including allergies) | | | | Yes  No  Don’t know | |
| **Previous mental health support (e.g. CAMHS, Counselling, Educational Psychologist)** | | | | Yes  No  Don’t know | |
| Please provide more details: | | | | | |

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| **Please give a summary of the concerns the child/young person/family is experiencing. Please** include background information. E.g. When this started; how things are now; what support is in place; and describe the impact on daily life. |
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| **Are you aware of any current or previous risks associated with working with this CHILD/young person/family?**  (please include any risks to self; to others; from others; and any safeguarding concerns.) |
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| **Please list any other agencies CURRENTLY OR PREVIOUSLY involved in supporting the CHILD/young person/family; WHAT HAS HELPED AND WHAT HAS NOT?** |
| (please include any contact details, including phone numbers and email addresses.) |
| **Does the family/parent/carer (if under 16), or young person, consent to Compass contacting these Agencies to discuss the referral if required? Yes  No** |
| **What would the PARENT/CARER/family, or referrer if different, like to achieve by accessing Compass Shine Coventry?** |
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| **Any other relevant information:**  *(Including: family, social, educational factors, school attendance and school attainment level.)* |
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| **WHAT IS IMPORTANT TO THE FAMILY, CHILD, OR YOUNG PERSON REFERRED?** |
| **What is enjoyable?** (e.g. playing computer games, drawing, baking, riding your bike etc.) |
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| **What sorts of things are difficult?** (e.g. going to school/college, going out, meeting new people etc.) |
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| **What would you like to get better?** (e.g. to not feel so worried about things, feel happier etc.) |
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| **CONSENT STATEMENT** |
| Please send your completed Request for Support form, securely to: [compass.cypeip@nhs.net](mailto:compass.cypeip@nhs.net) |
| If you are unable to send the form electronically, mark confidential and post or hand deliver to:  Compass Shine  Office 8, 209 William House  Torrington Avenue  Coventry  CV4 9AS  For any queries please contact Compass Coventry on Tel: 024 7518 6206 |
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| **OFFICE USE ONLY** | |
| Date referral received: | Receiving Worker: |
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