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| 1. **Privacy Notice Statement & CONSENT**
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| **Please note by completing this request for support form, Compass will expect the following (please tick to confirm):** 1. This referral has been discussed and agreed with the person concerned [ ]
2. You consider the person to have capacity to give informed consent [ ]
3. If the person does not have capacity to consent, you have consulted with the parent/carer/advocate. [ ]
4. You have explained that any information held on this form will be stored by Compass on a secure database [ ]

**If the referral is for a young person:**1. Does the parent/carer (if under 16) or young person, consent to Compass contacting other agencies to discuss the referral if required? Yes [ ]  No [ ]
2. Does the child/young person consent to us contacting their parent/carer?Yes [ ]  No [ ]

**PLEASE NOTE: We will be unable to progress with a request for support without confirmation that consent has been appropriately discussed and agreed.** |

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| **Compass Wakefield Emotional Wellbeing Service** provides early intervention and support to children, young people, families and communities to develop the knowledge, skills and confidence to build and maintain the emotional health and wellbeing of children and young people.Helpful topical information, advice, and self-help materials are easily available at [www.wf-i-can.co.uk](http://www.wf-i-can.co.uk)The service provides a free texting service in partnership with SHOUT 24 hours a day, 7 days a week for confidential help. To access this service text **BUZZ** to **85258**. The service provides tailored advice and information and/or guided self-help through goal-based interventions on either an individual or group basis. To access advice or support please contact us on **01924 665093** Monday – Friday 9.00am t0 4.30pm or complete the request for support form and return it to WakefieldCYPEWS@Compass-uk.org.Please tick the box below indicating the purpose of your request: To access emotional wellbeing support for a child or young person [ ]  To access bereavement support for a child or young person [ ] Advice and Information for: A child or young person [ ]  A parent or carer [ ]  Something else [ ]  Please tell us here about your request…………………………………………………………………………….……………………………………………………………………………………………………………………………………………………………..***Please note that it may hold up the referral if Compass is unable to speak with the referrer following this request.*** |
| **CONTACT DETAILS FOR PERSON MAKING REQUEST** |
| **Name:**  | **Relationship:**  |
| **Organisation (if applicable):**  |
| **Address:**  |
| **Contact phone number:**  |
| **E-mail address:**  |
| **Has the child/young person/parent/carer consented to being contacted via phone?** Yes [ ]  No [ ]  |
| **Has the child/young person/parent/carer consented to being contacted via text message?** Yes [ ]  No [ ]  |
| **Has the child/young person/ parent/carer consented to being contacted via email?** Yes [ ]  No [ ]  |
| **DETAILS OF THE PERSON REFERRED** |
| **Full name**  | **Preferred name:**  |
| **Address:**  |
|  (*NB we may correspond by post unless you instruct us not to)* **Postcode:**  |
| **Mobile phone number:** (*NB we may leave a message on this phone number unless you tell us not to)*  |
| **Landline phone number:** (*NB we may leave a message on this phone number unless you tell us not to)* |
| **Date of birth:**  | **Age:**  |
| **Gender:**  | **Religion:**  |
| **Ethnicity:**  | White British [ ] White Irish [ ] Any other white background [ ] Mixed White and Black Caribbean [ ] Mixed White and Black African [ ]  Mixed White and Asian [ ] Any other Mixed Background [ ] Asian or Asian British – Indian [ ] Asian or Asian British – Pakistani [ ] Asian or Asian British – Bangladeshi [ ] Any other Asian Background [ ]  | Black or Black British – Caribbean [ ] Black or Black British – African [ ] Black or Black British – Other [ ] Other Ethnic group – Chinese [ ] Any other ethnic group (state)……………………..**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, independent living) |
| **Are there any methods by which the person does NOT want to be contacted?** |
| **Are there any additional needs Compass will need to be aware of to help the CYP/family engage?** This may include accessibility/hearing impairment/communication methods. |
| **IF THE REQUEST IS FOR A PERSON UNDER 18 YEARS OF AGE PLEASE PROVIDE CONTACT DETAILS OF PARENTS / CARERS** |
|  | **Parent/Carer One** | **Parent/Carer Two** (optional) |
| **Name:** |  |  |
| **Relationship:** |  |  |
| **Address:**  |   |  |
| **Contact phone number:**  |  |  |
| **E-mail address:**  |   |  |
| **Main language:** |  |  |
| **Is an interpreter required?** |  |  |
| **SCHOOL/COLLEGE DETAILS (if applicable)** |
| **Name of the school the young person attends:**  |
| **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:**  |
|  |
| **DOES THE PERSON HAVE ANY ADDITIONAL NEEDS**  |
| Subject to a CPP  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Elected Home Educated  | Yes [ ]  No [ ]  Don’t know [ ]  |
| LAC/Care Leaver  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Young Carer  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Excluded / at risk of  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Substance Misuse  | Yes [ ]  No [ ]  Don’t know [ ]  |
| NEET | Yes [ ]  No [ ]  Don’t know [ ]  |
| Free school meals | Yes [ ]  No [ ]  Don’t know [ ]  |
| Financial hardship | Yes [ ]  No [ ]  Don’t know [ ]  |
| Special Educational Need or Disability (SEND)  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Neurodiverse Diagnosis (e.g. ASD, ADHD) | 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 [ ]  |
| Mental health diagnosis (e.g. PTSD, OCD, anxiety, depression) | Yes [ ]  No [ ]  Don’t know [ ]  |
| Previous mental health intervention (e.g. CAMHS, counsellor, Psychologist) | Yes [ ]  No [ ]  Don’t know [ ]  |
| Please provide more details: **If you have ticked Yes to any of the above please provide further information** |
| **PREVIOUSLY SUPPORTED BY:**  |
| CAMHS  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Future In Mind  | Yes [ ]  No [ ]  Don’t know [ ]  |
| 0-19 School Nursing Service  | Yes [ ]  No [ ]  Don’t know [ ]  |
| I-SPACE  | Yes [ ]  No [ ]  Don’t know [ ]  |
| STAR Bereavement  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Other (Please list):  |
| WHAT SUPPORT WAS DELIVERED, HOW MANY SESSIONS AND WHEN DID THIS SUPPORT END? |

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| **cURRENT REFERRAL MADE TO THE FOLLOWING SERVICES:**  |
| CAMHS  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Future In Mind  | Yes [ ]  No [ ]  Don’t know [ ]  |
| 0-19 School Nursing Service  | Yes [ ]  No [ ]  Don’t know [ ]  |
| I-SPACE  | Yes [ ]  No [ ]  Don’t know [ ]  |
| STAR Bereavement  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Other (Please list):  |
| **what is the reason for referral?** |
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| **Are you aware of any current or previous risks associated with working with this person?**(please include any risks to self, others and safeguarding concerns)  |
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| **PLEASE TELL US ABOUT ANY OTHER SERVICES SUPPORTING THE FAMILY.** (This might include CAMHS, Early Help, School Nursing, social worker or others). |
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| **Any other relevant information:** (Including: family, social, educational factors, disability or communication needs) |
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| **What is important to the person referred?** |
| **What would you most like help with?** |
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| **What sort of things do you find most difficult?** |
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| **How would you like things to improve?** |
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| Please send your completed Request for Support form, securely to: WakefieldCYPEWS@Compass-uk.orgIf you are unable to send the form electronically please contact Compass on 01924 665093 – Monday – Friday 09.00 – 16.30 hours. |