**ME AND US REFERRAL FORM**

This programme aims to provide children with an opportunity to explore and learn what relationships are all about. It considers what makes a relationship healthy or unhealthy. What behaviours are acceptable or unacceptable and what is domestic abuse?

The programme aims to equip children with the knowledge to make safe choices and have the confidence to share concerns with their trusted adults.

The group runs for 10 weeks and sessions last 1hr 15mins.

|  |  |
| --- | --- |
| **Information about the person making the referral** | |
|  | |
| Date of referral: |  |
| Name of Programme: |  |
| **Please ensure all below sections are completed** | |
| Referrer’s name (if applicable) |  |
| Organisation name (if applicable) |  |
| Role/ job title (if applicable) |  |
| Contact number |  |
| Contact email |  |

**Child and parent/carer contact information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| Child’s First name |  | | | |
| Child’s Last name |  | | | |
| What do they like to be called? |  | | | |
| DOB |  | | | |
| **Current address** |  | | | |
| Does the perpetrator live at this address? | Yes  No  Don’t Know | | | |
| **Parent /Carer Contact Info** *Details Safe to contact?* | | | | |
| Name |  | | |  |
| DOB |  | | |  |
| Contact Number |  | | |  |
| Is it safe to leave message |  | | |  |
| Email |  | | |  |
| **Please provide a safe additional contact for emergency purposes ONLY** | | | | |
| Name & relationship to client |  | | |  |
| Contact Number |  | | |  |
| **Any additional safety notes please record here:** | | | | |
| **Reason for referral:** | | | | |
| **Has parental consent been given -** | | Yes | No | |

**Additional Needs and involvement**

|  |  |  |
| --- | --- | --- |
| Is there any social care involvement in this case? | Yes | No |
| *(Please provide details including any plans)* |  | |
| Name of allocated worker and contact details  *(if relevant)* |  | |
| Does client have additional needs? | Yes | No |
| If yes please provide an overview of support needs |  | |

**Client equalities monitoring**

|  |  |  |
| --- | --- | --- |
| Client Gender | Female | Male |
| Do they have any kind of disability?  (please tick any that apply) | Physical  Learning  Mental Health  Deaf/ hearing impaired  Blind/ visually impaired  Something else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| How would they describe their ethnicity? | | |
| White British  White Irish  White Gypsy or Irish Traveller  Any other White background  Asian British  Asian Indian  Asian Pakistani  Asian Bangladeshi  Any other Asian background  Chinese  Arab | White and Black Caribbean  White and Black African  White and Asian  Any other mixed/ multiple background  Black British  Black African  Black Caribbean  Any other Black background  Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| Do they have a faith/ religion? | | |
| No religion  Bahai  Buddhist  Christian  Hindu  Jewish  Jain | Muslim  Shinto  Sikh  Zoroastrian  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Don’t Know | |
| What is client’s nationality? |  | |

**To submit this referral please email it to advice@ndas-org.co.uk**

**If you have any queries, please email** **advice@ndas-org.co.uk** or call **0300 0120154**.