Oasis Domestic Abuse Service Children and Young Person’s Referral Form

**How to complete this referral:**

By completing this referral form, you’re helping us to make contact with the client as safely and quickly as possible. We’d appreciate it if you could include as much information as possible - this saves the client from being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**Eligibility criteria for this service:**

Oasis children’s and young people’s services are dependent on the generosity of our funders, who pay for projects with particular criteria. Please complete all relevant boxes below for us to decide which service best fits the needs of the young person. There may be times that we do not have funding to meet their needs, if this is the case, we will contact you to discuss this.

**How to get in touch:**

If you have any questions about our service, eligibility criteria, or how to make a referral, please contact the EIP team on:

**Thanet and Dover**

**eip@oasisdaservice.org**

Mobile: 07718657157

**North Kent & Medway**

**referrals@oasisdaservice.org**

Helpline: 0800 917 9948

**How to submit this referral:**

Please email the completed, password protected form (sending the password separately to the document), using the details above.

|  |
| --- |
| **Information about the person making the referral** |
|  |
| Date of referral: |  |
| **Please tick all boxes that apply to the young person or service required.** |
|  | Affected by DA at home |  | Vulnerable to CCE |
|  | Experiencing DA in relationships |  | Vulnerable to CSE |
|  | Exhibiting abusive behaviours |  | ACE affected |
| **Please enter your name and contact details:**  |
| Referrer’s name |  |
| Organisation name |  |
| Role/ job title |  |
| Contact number  |  |
| Contact email |  |
| **CYP contact info** |
| **Names**  |
| Young person’s full name |  |
| What do they like to be called? |  |
| DOB |  |
| Gender |  |
| Parent/ carer name |  |
| **Contact info for this referral** |
| Please contact: | CYP directly [ ] Parent/ Carer [ ]  |
|  | *Safe to contact?* |
| Phone |  |[ ]
| Email  |  |[ ]
| Current address |  |[ ]
| Safe contact notes *(is it safe to text, voice mail. post? Are there safer times to make contact?)* |  |
| **School/ college/ nursery info:** | **GP Name and Address:**  |
|  |  |
| **Relationships** |
| Alleged perpetrator name(s) |  |
| Alleged perpetrator relationship to child |  |
| Does the CYP have any contact with the alleged perpetrator | *Please give details including any conflicts within the family* |
| **Next of kin – who can we contact in an emergency?** |
| Name  |  | Relationship |  |
| Contact information  |  |
| Safe contact notes |  |
| **Safeguarding**  |
| Are children’s services involved in this case? | Yes [ ]  No[ ]  Don’t Know [ ]  |
| Level/ nature of involvement – notes: |  |
| Contact detail of other agencies involved with the CYP.  |  |
| **Accessibility requirements**  |
| Does this client have any accessibility requirements (for example, hearing loop, braille documents) | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| Does this client require an interpreter? | Yes [ ]  No[ ]  Don’t Know [ ]  | *If yes, please provide details:* |
| **Client support needs/ vulnerabilities**  |
| ***Please tell us more about any support need the client may have:*** |
| Mental Health [ ] Physical Health [ ] Sexual Health [ ]  Substance misuse [ ] Aggressive behaviour [ ]  Adolescent to Parent Violence [ ] Self-harming/ suicidal feelings [ ]   | Issues with educational attainment/ attendance [ ]  Domestic abuse in home [ ] Social isolation [ ] Bullying/ being bullied [ ]  Experiencing abuse [ ] Other *(please specify below)*  |
| **Additional details:** |
|  |
| **Why are you making this referral – how could this client benefit from our support?** |
|  |
| **Are there any known risks to working with this client?**  |
|  |

**Please ensure that parental consent has been gained for a CYP under the age of 13.**

I have obtained permission for Oasis to contact the parent/ carer about this referral. [ ]

The parent/carer does not wish to be contacted by Oasis but has given consent for CYP’s referral. [ ]

Parental consent is not necessary for this referral as the CYP is over the age of 13 and gillick competent. [ ]

I have been unable to speak to the parent/carer about this referral. [ ]

**Thank you for taking the time to complete this referral.**