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| 1. **Privacy Notice Statement & CONSENT** | | | | | | |
| **Please note by completing this referral, Compass will expect the following (please tick to confirm):**   1. This referral has been discussed and agreed by the person requesting support 2. You consider the person to have capacity to give informed consent 3. 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: This referral will not be processed if any of the boxes above have not been completed or consent is not signed.**  Signed by - Referrer: ……………....… Referred person: …………....….. Parent/carer (if applicable): …………..….... | | | | | | |
| Compass Be works with children, young people, families, and schools to provide low intensity one-to-one interventions (8 – 10 sessions) and group work for mild to moderate emotional health and wellbeing needs and those who experience higher levels of distress following a bereavement.  To make a referral to Compass Be please note the following inclusion and exclusion criteria.  Compass Be, **can** support children and young people with (please tick those that apply):  Bereavement.  Low mood: sadness, low motivation  Mild to moderate anxiety: worries, irrational fears, and concerns  Common challenging behaviours; angry outbursts, pushing boundaries, frustration, and distress.  Family and peer relationship difficulties  Difficulty adjusting to change and transition.  Difficulty managing emotions.  Compass Be **cannot** provide bereavement support to children, young people and adults who:   * Have a clinical diagnosis of ‘clinical’ depression, severe anxiety, Obsessive-Compulsive Disorder (OCD), schizophrenia, eating disorders, psychosis. * Have self-harmed long term and currently experiencing suicidal thoughts/behaviours. * Have a moderate – severe learning disability. * Are requiring long-term therapy. * Are in crisis or requiring out of hours support.   **PLEASE NOTE**:  If you are unsure whether a child, young person or adult would benefit from Bereavement Support please call our duty team on **01904 666371** (Monday – Thursday 9am to 4.30pm / Friday 9am to 4.00pm). | | | | | | |
| 1. **REFERRER DETAILS** | | | | | | |
| Name: | Relationship to the referred person: | | | | | |
| Organisation (if applicable): | | | | | | |
| Address: | | | | | | |
| Contact phone number: | | | | | | |
| Email address: | | | | | | |
| Have you spoken with a MHST link worker or duty worker? Yes ☐ Who?........................... No ☐ | | | | | | |
| How did you hear about Compass Be? | | | | | | |
| 1. **ABOUT THE REFERRED PERSON** | | | | | | |
| Full name: | | | Preferred name/pronoun: | | | |
| Address: | | | | | | |
| Mobile phone number/landline number: | | | | | | |
| Date of birth: | | | | Age: | | |
| Gender: | | | | Religion: | | |
| Ethnicity:  White British  White other  Mixed  Asian or Asian British  Black or Black British  Other Ethnic Groups  Not known  Other If other, please specify: ……………….…………………………. | | | | Main Language:  Is an interpreter required? Yes/No  Documents required in main language? Yes/No | | |
| Next of Kin: | | | | | | |
| Accommodation status:  (i.e. living with parents, living with relatives, fostered, adopted, independent living) | | | | | | |
| Are there any methods by which the child/young person does NOT want to be contacted?  (Unless stated otherwise we will call, text, email and send letters when relevant) | | | | | | |
| 1. **CONTACT DETAILS OF PARENT/CARER (if applicable)** | | | | | | |
| Name: | | Relationship: | | | | |
| Address: | | | | | | |
| Phone number: | | | | | | |
| Email address: | | | | | | |
| Is an interpreter required? | | | | | Is an interpreter required? | |
| Are there any methods by which the parent/carer does NOT want to be contacted?  (Unless stated otherwise we will call, text, email and send letters when relevant) | | | | | | |
| 1. **SCHOOL/COLLEGE DETAILS (if applicable)** | | | | | | |
| Name of the school: | | | | | | |
| Year group: | | | | | | |
| Name of key contact / member of staff at school: | | | | | | |
| 1. **GP DETAILS** | | | | | | |
| GP Name: | | | | | | |
| Name and Address of G.P Surgery: | | | | | | |
| Phone Number: | | | | | | |
| Email address: | | | | | | |
| 1. **DOES THE PERSON BEING REFERRED HAVE ANY ADDITIONAL NEEDS** | | | | | | |
| Child protection plan | | | | | | Yes  No  Don’t know |
| Child in need | | | | | | Yes  No  Don’t know |
| Early Help | | | | | | 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 |
| Special Educational Need or Disability (SEND) | | | | | | Yes  No  Don’t know |
| Physical health needs (including allergies) | | | | | | Yes  No  Don’t know |
| Education Health and Care Plan (EHCP) | | | | | | Yes  No  Don’t know |
| If any of the above are YES, please provide more details: | | | | | | |
| 1. **ABOUT THE LOSS** | | | | | | |
| Who has passed away: | | | | | Relationship to referred person: | |
| Date of the loss: | | | | | Circumstances around the loss: | |
| 1. **Please PROVIDE DETAILS OF THE DIfficulties BEING experiencED FOLLOWING THE LOSS:**   (What is the reason for referral? What is the impact of this? What has been tried before?) | | | | | | |
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| 1. **WHAT WOULD THE REFERRED PERSON LIKE TO ACHIEVE FROM THE SUPPORT?** | | | | | | |
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| 1. **ARE YOu AWARE OF ANY CURRENT PERSON/FAMILY OR PREVIOUS RISKS WITH THe referred person?**   (Please include risk to self, others and/or safeguarding concerns, appropriate for home visits.  Please attach any current or previous risk assessment if applicable) | | | | | | |
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| 1. **Please list any other agencies involved in supporting ther referred person** (Please list contact names/numbers if known) | | | | | | |
| Current support: | | | | | Previous support (including dates): | |
| ONCE COMPLETE PLEASE SEND THE COMPLETED FORM TO: | | | | | | |
| **Secure\* email address:** [**info**.**barnsleymhst@Compass-uk.org**](mailto:info.barnsleymhst@Compass-uk.org)  \*NB In order for this to remain secure please use an EGRESS email address to send the referral if possible  **Postal address:**  Compass Be  Unit 15 Churchfield Court, Barnsley, South Yorkshire, S70 2JT | | | | | | |