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**Agency Referral Form – Friendship Works Youth Mentoring**

**Children’s (core) Referral Form**

**Please fill in the form and return in a password protected format to us at:**

[**info@friendshipworks.org.uk**](mailto:info@friendshipworks.org.uk)**;**

**www.family-action.org.uk/what-we-do/children-families/mentoring/friendshipworks**

**Family Action/Friendship Works: 3 Wharf Studios, 34 Wharf Road, London N1 7GR.**

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| **Please note the following:** | |
| Children’s (core) service is for 5-16 years (at point of referral): | Referrals with insufficient or inaccurate information cannot be screened. A case it not ‘live’ until it is allocated. Comprehensive information is required for referrals forms due to the long-term nature of the service. |

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| Please verify that you have discussed Friendship Works youth mentoring with the child/parent/carer and confirm that they are interested in learning more about the service, *and* that they understand this programme is voluntary/consent based. | **YES – I HAVE CONSENT** | **NO – I DO NOT HAVE CONSENT** |
|  | **PLEASE DO NOT SEND REFERRALS WITHOUT EXPLICIT CONSENT** |

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| **Referral details: Please clearly mark ‘X’ for selected answers.** | | | | | |
| Name of child: |  | | | | |
| Date of birth and age: |  | | | | |
| Gender identity: | MALE: | | |  | |
| FEMALE: | | |  | |
| NON-BINARY: | | |  | |
| OTHER (please state): | | |  | |
| Do they identify as Transgender? |  | | | | |
| Please state preferred pronouns: |  | | | | |
| Ethnicity: | White British |  | White Irish | |  |
| White and Black African |  | White and Black Caribbean | |  |
| White and Asian |  | Other White background | |  |
| Indian |  | Pakistani | |  |
| Bangladeshi |  | Other Asian background | |  |
| Caribbean |  | African | |  |
| Other Black background |  | Chinese | |  |
| Other ethnic group (please state): |  | Unknown | |  |

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| **Personal details:** | | | | |
| Where does the child live: | BIRTH FAMILY: | |  | |
| ADOPTED FAMILY: | |  | |
| FOSTER CARE: | |  | |
| KINSHIP CARE: | |  | |
| RESIDENTIAL UNIT: | |  | |
| OTHER: | |  | |
| Please outline any contact with parent/s they are not currently living at with: | FREQUENT: | |  | |
| OCCASSIONAL: | |  | |
| NEVER: | |  | |
| Parent/Carer/Guardians full name: |  | | | |
| Who holds parental responsibility? | NAME(S): | |  | |
| TELEPHONE NUMBER: | |  | |
| Address(s) including Local Authority: |  | | | |
| Telephone number/email address and preferred method of contact: |  | | | |
| Current legal or historic status of child: | LOOKED AFTER CHILD: | |  | |
| CHILD PROTECTION PLAN - please state type i.e. physical, sexual, emotional or neglect. | |  | |
| CHILD IN NEED PLAN:- please state type i.e. physical, sexual, emotional or neglect. | |  | |
| SUPERVISION ORDER OR FORMALISED CONTACT ARRANGEMENT: | |  | |
| UNACCOUNPANIED MINOR: | |  | |
| REFUGEE: | |  | |
| ASYLUM SEEKER: | |  | |
| NO RECOURSE TO PUBLIC FUNDS: | |  | |
| GUARDIANSHIP/CAPACITY: | |  | |
| HISTORIC STATUS(S) INCLUDING ANY OF THE ABOVE: | |  | |
| Language spoken within home: |  | | | |
| Is an interpreter required to communicate with any of the following:  Child/parent/carer: |  | | | |
| If yes, please state which language: |  | | | |
| Who else lives in the home:  (please add any extra residents or siblings if necessary) | NAMES: | RELATION: | | DOB AND AGE: |
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| Any additional information or details of family background: |  | | | |

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| **Referrer and relevant contact details:** | |
| Name and role of referrer: |  |
| Organisation: |  |
| Address: |  |
| Telephone number: |  |
| Email: |  |
| What is your involvement with the child – what support are you currently providing: |  |
| How long have you known the child: |  |
| State when you are or plan to close the case: |  |
| State whether you (referrer) can be present at initial meeting to discuss the service: |  |
| Name and contact details of allocated Early Help or Social Worker: |  |

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| **Please list any other agencies currently working with the child or primary care giver:** | |
| CAHMS: |  |
| ADULT MENTAL HEALTH SERVICES: |  |
| CRIMINAL JUSTICE/YOUTH OFFENDING OR POLICE INVOLVEMENT: |  |
| ADVOCACY SERVICES: |  |
| INDEPENDENT VISITOR: |  |
| OTHER *(please list):* |  |

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| Does the child or primary carer have a suspected or diagnosed disability? I.e. behavioural/emotional, sensory, physical, developmental or ‘invisible’ (please provide more details): |
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| **Experience of school or further education setting:** | | | | | | | | |
| Name of child’s school/ education setting: |  | | | | | | | |
| Contact person in school/education setting: |  | | | | | | | |
| School/education setting address, email and telephone number: |  | | | | | | | |
| Experience of education: | GOOD | | AVERAGE | | BELOW AVERAGE | | UNKNOWN | |
| Attendance |  | |  | |  | |  | |
| Behaviour |  | |  | |  | |  | |
| Performance: |  | |  | |  | |  | |
| Is the child: | EXCLUDED FROM SCHOOL | A SCHOOL REFUSER | | A YOUNG CARER | | HAS AN EHCP | | ATTENDS A PRU OR ALTERNATIVE PROVISION |
|  |  | |  | |  | |  |
| List further relevant details regarding school/further education: |  | | | | | | | |

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| **Referral details:** | |
| The overall aims and basic minimum criteria of the service are listed below. Please outline:   * Why it is your assessment that this child has the need for the long term support of an adult mentor and why it is your assessment that this child/family can safely engage with this type of long-term mentoring? | |
| 1. To improve children and young people’s social and emotional development through access to quality friendship, increasing ability to understand others, manage and express feelings; show empathy; make and maintain positive relationships and attachments. Please expand: |  |
| 1. To enable children and young people to have a better view of themselves, and a strong sense of their identity and increased resilience; increased self esteem and self confidence, sense of self control, self efficacy and self determination. Please expand: |  |
| 1. To broaden young people’s horizons through access to new opportunities; increased access to fun and play, develop new hobbies, leisure interests and promotion of talents.Please expand: |  |
| 1. This service is for children facing multiple disadvantages and challenges in their lives. Please expand: |  |
| 1. The child will meet with their adult mentor x3 meetings per month for a minimum of 2 years for activities *outside of home*. This requires a basic minimum level of sustained engagement from both the primary carer/child. Why do you believe the child/parent can engage and how do you think this will work? Please expand: |  |

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| **Risk assessment:** | | |
| Are any of the following concerns relevant for the child or primary carer: | | |
| Lived experience or signs of: | WHO AND WHAT: | CURRENT OR HISTORIC: |
| Verbal or physical conflict aimed towards those outside of the family, i.e. professionals: |  |  |
| Discriminatory abuse, i.e. unequal treatment of an individual based on age, gender, gender-reassignment, marriage, maternity, race, religion, belief, sex or sexual orientation. |  |  |
| Sexual abuse or risk of: |  |  |
| Domestic abuse/violence, including coercive control: |  |  |
| Psychological or emotional abuse: |  |  |
| Financial or material abuse: |  |  |
| Substance misuse including drugs and alcohol: |  |  |
| Risky online behaviour: |  |  |
| Mental health issues, including self-harm: |  |  |
| Episodes of going missing: |  |  |
| Criminal behaviour/at risk of, including radicalisation: |  |  |
| Homelessness/at risk of, including temporary accommodation: |  |  |
| Difficult peer relationships, i.e. cyber bullying: |  |  |
| Gang affiliation/at risk of: |  |  |
| Grooming/at risk of: |  |  |
| Trafficking or modern slavery: |  |  |
| Female genital mutilation: |  |  |
| Self-neglect: |  |  |
| If you have indicated any of these risks are current please provide more details including any actions being taken to minimise risk:  Please note: we encourage referrers to share risk assessments with us once consent has been obtained. |  | |

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| Tell us how you heard about Friendship Works: |  |

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| Signature of referrer: |  |
| Date of referral: |  |