**Professional referral form**

**Service information**

Know Your Mind is Mind in Bradford’s children and young people’s service; providing mental health and emotional wellbeing support to young people aged 8-19 (or up to 25 with special educational needs and disabilities) with mild to moderate mental health difficulties in the Bradford Central area (living in, go to school in, or attend a GP surgery in postcodes BD1, BD2, BD3, BD5, BD7, BD8 or BD9). We provide group support as well as some 1:1 support, using a goal-based approach to tailor support to a young person’s specific needs. More information can be found on our website, [mindinbradford.org.uk](https://www.mindinbradford.org.uk/).

**Please note:**Due to COVID-19 restrictions we are currently offering virtual online and telephone support, although we will be introducing limited face to face services when appropriate.

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the young person have access to a computer, tablet, laptop or phone that will allow them to talk to us via telephone or online video call?** | | | |
| Yes |  | Details: |  |
| No |  |  |

**Young Person’s Details**

|  |  |
| --- | --- |
| **Personal Details** | |
| Name: |  |
| Preferred Name (if different): |  |
| Preferred Pronouns: |  |
| Date of Birth: |  |
| Address: |  |
| Contact Number: |  |
| Email Address: |  |
| Please provide details of any language/interpretation or communication needs, or other accessibility requirements: |  |
| **GP Details** | |
| GP Surgery: |  |
| GP Name: |  |
| GP Contact Number: |  |

|  |  |
| --- | --- |
| **School Details** | |
| School Name: |  |
| School Year: |  |
| Does YP have a Key Worker? | Yes / No (please delete) |
| Name of Key Worker: |  |
| Key Worker Phone Number: |  |
| Key Worker Email: |  |
| Attendance and/or Attainment Difficulties: |  |

|  |  |
| --- | --- |
| **Please select the statements that apply to the young person:** | |
| Public health research has identified that there are certain ‘groups’ who are not accessing mental health and wellbeing services and receiving the support they need. We would like to ensure we are prioritising young people who find themselves in one of the following categories when delivering our services. | |
| In Year 6, 7, 11, 12 or 13 at school/college |  |
| Engaging in behaviours that may get them in trouble with the police |  |
| Not regularly attending school or on a reduced timetable |  |
| Experiencing or witnessing domestic violence |  |
| Have a disability or special educational needs |  |
| Living in care (including foster care) and/or leaving care |  |
| Refugee or Asylum Seeker |  |
| On a child in need or child protection plan |  |
| None of the above |  |

**Referrer Details**

|  |  |
| --- | --- |
| **Referrer Contact Details** | |
| Name: |  |
| Job Title: |  |
| Organisation: |  |
| Contact Number: |  |
| Email: |  |

**Parent/Guardian Details**

|  |  |
| --- | --- |
| **Parent/Guardian Details** | |
| Full Name: |  |
| Address (if different): |  |
| Contact Number: |  |
| What is their relationship to young person? |  |
| Full Name: |  |
| Address (if different): |  |
| Contact Number: |  |
| What is their relationship to young person? |  |
| Does young person have any siblings? |  |
| Siblings Names and Ages: |  |
| Who does young person live with? (mum/dad/grandparents etc.) |  |
| Is there any other information you would like to make us aware of regarding family/living circumstances? |  |

**Reason for referral/presenting problem**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please select the primary reason for referral:** | | | |
| Suspected first episode of psychosis |  | Ongoing or recurrent psychosis |  |
| Bi polar disorder |  | Depression |  |
| Anxiety |  | Obsessive compulsive disorder |  |
| Phobias |  | Drug & alcohol difficulties |  |
| Post-traumatic stress disorder |  | Eating disorders |  |
| Personality disorders |  | Self-harm behaviours |  |
| Conduct disorders |  | Relationship difficulties |  |
| Gender discomfort issues |  | Attachment difficulties |  |
| Self-care issues |  | Diagnosed Autism Spectrum Disorder |  |
| Gambling disorder |  | Neurodevelopmental conditions (excluding Autism Spectrum Disorder) |  |
| Suspected Autism Spectrum Disorder |  |

|  |
| --- |
| **Please select the primary reason for referral - Continued** |
| **Please describe the problem and in what ways the problem is adversely affecting the child and family. Please identify specific mental health concerns where relevant.** |
| **How long has the issue been going on and how often is it happening?** |
| **Expectations of the service/s: What does the young person, parent/guardians and referrer think will help, and what outcomes do they want to be achieved?** |

**Wellbeing – Worries, strengths and goals**

|  |  |  |  |
| --- | --- | --- | --- |
| **What is the young person worried about? (tick all the apply)** | | | |
| Loneliness / social isolation |  | Risk taking behaviours (e.g. drug misuse) |  |
| Mental health / emotional wellbeing |  | Friends / relationships |  |
| Activities / opportunities |  | Family / home life |  |
| Low confidence / self esteem |  | Education / training / employment |  |
| Struggling with identity |  | Physical health / illness / disability |  |
| Safety – self-harm / suicidal ideation |  | Self-care |  |
| Safety – abuse, exploitation, bullying |  | Caring responsibilities |  |
| **More details about worries and concerns:** | | | |
| **What does the young person feel is going well? (tick all that apply)** | | | |
| Friends / social connections |  | Friends / relationships |  |
| Community involvement |  | Family relationships / home life |  |
| Hobbies / interests |  | School / education / employment |  |
| Identity  / confidence / self esteem |  | Physical health |  |
| Positively managing risk |  | Mental Health / emotional wellbeing |  |
| Future plans |  | Coping strategies / self-care |  |
| Networks of support |  | Independence |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **What does the young person feel is going well? - Continued** | | | |
| **More details about strengths and protective factors:** | | | |
| **What needs to happen to improve things for the young person, what are their goals? (tick all that apply)** | | | |
| Reduce loneliness or isolation |  | Build & maintain positive relationships |  |
| Community involvement |  | Improve family relationships / home life |  |
| Develop hobbies / interests |  | Learn independent living skills |  |
| Increase confidence, self-esteem |  | Improve physical wellbeing |  |
| Stronger sense of identity |  | Self-manage emotional wellbeing |  |
| Make plans for short or long term future |  | Return to education |  |
| Manage risk more effectively & feel safer |  | Build strong network of support |  |
| Develop employment/training opportunities |  | Other (please describe below) |  |
| **More details about goals and what needs to improve:** | | | |

**Risk Assessment**

**When completing this section, please think about current and relevant historical risk.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Have there been any safeguarding concerns about the young person?** | | | |
| Yes |  | No |  |
| If yes, please describe and detail actions taken: | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk Information** | | | | | |
| For all risks, please give details in the spaces provided. | | | | | |
|  | No risk | Low | Med | High | Not known |
| **Risk to self** (e.g. substance misuse, self-harm, suicidal ideation, self-neglect) |  |  |  |  |  |
| Please give more details of risk to self, including protective/mitigating factors: | | | | | |
|  | No risk | Low | Med | High | Not known |
| **Risk to others** (e.g. aggressive, violent or inappropriate behaviour, threats, or intimidation, risk to staff, family, public, other young people) |  |  |  |  |  |
| Please give more details of risk to others, including protective/mitigating factors: | | | | | |
|  | No risk | Low | Med | High | Not known |
| **Risk from others:** (e.g. vulnerability, abuse, neglect, exploitation) |  |  |  |  |  |
| Please give more details of risk from others, including protective/mitigating factors: | | | | | |
|  | No risk | Low | Med | High | Not known |
| **Lone working risks:** (e.g. environmental risk (clutter/parking/street lighting/pets), risk to staff from family/others in local area) |  |  |  |  |  |
| Please give more details of lone working risks, including protective/mitigating factors: | | | | | |
| **Medical conditions and allergies** | | | | | |
| Please give details of any relevant medical conditions or allergies, for example epilepsy, asthma, allergies to food or materials. | | | | | |
|  | | | | | |

**Contact**

**Please select (x) below the days and times the young person is available for a member of our team to call them on the number provided above (personal details). Please select at least 3 options if possible.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| Morning (9am-12pm) |  |  |  |  |  |
| Afternoon (12pm-4pm) |  |  |  |  |  |
| Evening (4pm-7:00pm) |  |  |  |  |  |

**Consent**

|  |  |  |  |
| --- | --- | --- | --- |
| **Consent** | | | |
|  | | Yes | No |
| Is all information provided accurate and up to date at time of referral? | |  |  |
| Has informed consent to this referral been given by the young person? | |  |  |
| Have you provided the young person with a copy of the Mind in Bradford privacy notice? | |  |  |
| Date consent gained from young person: |  | | |
| **For under 13s:** | | | |
| Has informed consent to this referral been given by the parent/guardian? | |  |  |
| Have you provided the parent/guardian with a copy of the Mind in Bradford privacy notice for parents/guardians? | |  |  |
| Name of parent / guardian: |  | | |
| Relationship to young person: |  | | |
| Date consent gained: |  | | |

\*\*INCOMPLETE REFERRAL FORMS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO REFERRER\*\*

Please complete monitoring information below and send completed referrals to: [knowyourmind@mindinbradford.org.uk](mailto:knowyourmind@mindinbradford.org.uk)

**Monitoring Information**

We use this information to help us improve fair access to our services for all, and to understand if there are any groups of people we could be better at supporting.

The information is collected for monitoring purposes and will not affect your involvement with our services in any way. Summaries of demographic information may be shared with funders, but will not include personal details and cannot be linked back to an individual.

Your data is handled in line with the Data Protection Act (2018).

If you have any questions, please contact us at [knowyourmind@mindinbradford.org.uk](mailto:knowyourmind@mindinbradford.org.uk)

|  |  |  |  |
| --- | --- | --- | --- |
| **How would the young person describe their gender identity?** | | | |
| Female |  | Male |  |
| Non-Binary |  | Other (please specify) |  |
| Prefer not to say |  |  |  |
| **Is their gender identity the same as they were assigned at birth?** | | | |
| Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **How would the young person describe their ethnic background?** | | | |
| **Asian/Asian British** | | **White** | |
| Bangladeshi |  | English/Welsh/Scottish/Northern Irish/British |  |
| Chinese |  | Central or Eastern European |  |
| Indian |  | Irish |  |
| Pakistani |  | Gypsy or Irish Traveller |  |
| Other Asian |  | Other White |  |
| **Black/Black British** | | **Mixed or Multiple** | |
| African |  | Asian and White |  |
| Caribbean |  | Black African and White |  |
| Other Black |  | Black Caribbean and White |  |
| **Other Ethnic Group** | | Other Mixed |  |
| Arab |  | **Would prefer not to say** | |
| Any Other Ethnic Group |  | Would prefer not to say |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **How would the young person describe their sexual orientation?** | | | |
| Asexual |  | Bisexual |  |
| Heterosexual/Straight |  | Gay man |  |
| Gay woman |  | Pansexual |  |
| Other/would prefer to self-describe:  (Please state) ­­­\_\_\_\_\_\_\_\_\_\_\_ |  | Prefer not to say |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the young person consider themselves to be disabled?** | | | |
| Do you consider yourself to be disabled, or to have a long-standing condition or illness that causes difficulty with day-to-day activities? By long-standing we mean that is has lasted or is expected to last at least 12 months. | | | |
| Autism or other neurological difficulties |  | Cognitive or learning difficulties |  |
| Hearing or vision impairments |  | Invisible disabilities |  |
| Mental health |  | Physical |  |
| Other disability |  | No disability |  |
| Prefer not to say |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Would the young person describe themselves as a carer?** | | | |
| Yes |  | No |  |
| Prefer not to say |  |  | |