

MAKING TRACKS PROJECT REFERRAL FORM

Please post, fax or email this form to: YASP, 832 Stockport Road,
Levenshulme, Manchester, M19 3AW.

T: 0161 221 3054 F: 0161 221 3124 Email: info.yasp@harp-project.org

SECTION 1: YOUNG PERSON'S DETAILS:

1.1 First name: _____ Surname: _____

1.2 Age: _____ D.O.B: _____

1.3 Gender: Male Female Transgender Transsexual
Prefer not to say

1.4 Address: _____

_____ Postcode: _____

1.5 Email address: _____

Telephone number: _____

Can we send letters to this address: Yes: No:

Can we call you on this number: Yes: No:

Can we leave a message: Yes: No:

Can we text: Yes: No:

Can we email you: Yes: No:

1.6 Sexuality:

Bisexual Heterosexual / straight

Gay man Prefer not to say

Gay woman / lesbian

1.7 Does the young person have a:

Learning disability: Yes No Prefer not to say

Physical disability: Yes No Prefer not to say

Mental ill health: Yes No Prefer not to say

Physical ill health: Yes No Prefer not to say

1.8 Has the young person been given a medical diagnosis? Yes No

Prefer not to say

If yes please give details: _____

1.9 Ethnicity:

White

- White British
- White Irish
- Any other White background

Black or Black British

- Caribbean
- African
- Any other Black background

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background

Chinese or other ethnic group

- Chinese
- Other Chinese background
- Traveller of Irish Heritage
- Gypsy/Roma
- Other ethnic group
- Prefer not to say

1.10 First/preferred language, if not English:

- | | |
|--|---|
| • Albanian/Kosovan <input type="checkbox"/> | • Latvian <input type="checkbox"/> |
| • Arabic <input type="checkbox"/> | • Lithuanian <input type="checkbox"/> |
| • Bengali <input type="checkbox"/> | • Pashto <input type="checkbox"/> |
| • Bulgarian <input type="checkbox"/> | • Polish <input type="checkbox"/> |
| • Chinese (Cantonese) <input type="checkbox"/> | • Portuguese <input type="checkbox"/> |
| • Croatian <input type="checkbox"/> | • Punjabi <input type="checkbox"/> |
| • Czech <input type="checkbox"/> | • Romanian <input type="checkbox"/> |
| • Dari <input type="checkbox"/> | • Russian <input type="checkbox"/> |
| • Estonian <input type="checkbox"/> | • Serbian <input type="checkbox"/> |
| • Farsi /Persian <input type="checkbox"/> | • Slovak <input type="checkbox"/> |
| • French <input type="checkbox"/> | • Slovenian <input type="checkbox"/> |
| • German <input type="checkbox"/> | • Somali <input type="checkbox"/> |
| • Greek <input type="checkbox"/> | • Spanish <input type="checkbox"/> |
| • Gujarati <input type="checkbox"/> | • Swahili <input type="checkbox"/> |
| • Hindi <input type="checkbox"/> | • Turkish <input type="checkbox"/> |
| • Hungarian <input type="checkbox"/> | • Urdu <input type="checkbox"/> |
| • Italian <input type="checkbox"/> | • Vietnamese <input type="checkbox"/> |
| • Japanese <input type="checkbox"/> | • Other (please state) <input type="checkbox"/> |

1.11 Is an interpreter or signer needed? Yes No (if yes please give details)

1.12 Is the young person in care? Yes No Prefer not to say

1.13 Is the young person a care leaver? Yes No Prefer not to say

1.14 Is the young person subject to a court order i.e. attends the Youth Offending Team? Yes No Prefer not to say

1.15 Has the young person ever received a custodial sentence?

Yes No Prefer not to say

1.16 What's the young person's current housing status?

- | | | | |
|---------------------------------------|--------------------------|--------------------------------|--------------------------|
| • Adult Services residential care | <input type="checkbox"/> | • Living with friends | <input type="checkbox"/> |
| • Assured short hold tenant | <input type="checkbox"/> | • Sofa surfing | <input type="checkbox"/> |
| • B&B | <input type="checkbox"/> | • Staying with extended family | <input type="checkbox"/> |
| • Children's Services Care | <input type="checkbox"/> | • Street homeless | <input type="checkbox"/> |
| • Council tenant | <input type="checkbox"/> | • Student accommodation | <input type="checkbox"/> |
| • Hostel | <input type="checkbox"/> | • Supported lodgings | <input type="checkbox"/> |
| • Housing association | <input type="checkbox"/> | • Traveller | <input type="checkbox"/> |
| • Housing tenant (Assured short hold) | <input type="checkbox"/> | • Unauthorised occupants | <input type="checkbox"/> |
| • Licensee | <input type="checkbox"/> | • Prefer not to say | <input type="checkbox"/> |
| • Living with family | <input type="checkbox"/> | | |

1.17 Is the young person pregnant or expecting a child?

Yes No Prefer not to say

1.18 Is the young person a parent?

Yes No Prefer not to say

1.19 Is the young person the resident parent? Yes No Prefer not to say

1.20 What's the education status of the young person?

- | | | | |
|-----------------------|--------------------------|--|--------------------------|
| • Apprenticeship | <input type="checkbox"/> | • Training | <input type="checkbox"/> |
| • Full time education | <input type="checkbox"/> | • University | <input type="checkbox"/> |
| • Further education | <input type="checkbox"/> | • Not in education, employment or training NEET) | <input type="checkbox"/> |
| • Higher education | <input type="checkbox"/> | • Prefer not to say | <input type="checkbox"/> |
| • Part time education | <input type="checkbox"/> | | |

1.21 What is the young person's source of income?

- | | | | |
|---|--------------------------|--------------------------------------|--------------------------|
| • Apprenticeship | <input type="checkbox"/> | • JSA (CB) | <input type="checkbox"/> |
| • Carers allowance | <input type="checkbox"/> | • JSA (IB) | <input type="checkbox"/> |
| • Child benefit | <input type="checkbox"/> | • Maternity allowance | <input type="checkbox"/> |
| • Child tax credit | <input type="checkbox"/> | • Part time work | <input type="checkbox"/> |
| • DLA (Disability Living Allowance) | <input type="checkbox"/> | • SDA (Severe Disablement Allowance) | <input type="checkbox"/> |
| • Earned income or salary | <input type="checkbox"/> | • SMP (Statutory Maternity Pay) | <input type="checkbox"/> |
| • EMA (Education Maintenance Allowance) | <input type="checkbox"/> | • SPP (Statutory Paternity Pay) | <input type="checkbox"/> |

- | | | | |
|---|--------------------------|----------------------------|--------------------------|
| • ESA (CB) (employment and support allowance) | <input type="checkbox"/> | • SSP (Statutory Sick Pay) | <input type="checkbox"/> |
| • ESA (IB) (employment and support allowance) | <input type="checkbox"/> | • Student loan | <input type="checkbox"/> |
| • Full time work | <input type="checkbox"/> | • Working tax credit | <input type="checkbox"/> |
| • Housing Benefit | <input type="checkbox"/> | • None | <input type="checkbox"/> |
| • Incapacity Benefit | <input type="checkbox"/> | • Prefer not to say | <input type="checkbox"/> |
| • Income Support | <input type="checkbox"/> | | |

SECTION 2: REFERRER'S DETAILS:

2.1 Name of Referrer: _____ **Position:** _____

2.2 Address of Agency: _____

2.3 Referral type

- Self
- Agency referral
- Internal referral

2.4 Which agency has the referral come from?

External

- AMHS
 - CAFRASS (asylum/immigration agency)
 - CAMHS
 - Children's services
 - College
 - Drug/Alcohol service
 - Early Intervention Into Psychosis Team
 - GP/Nurse
 - Housing project/agency
 - PCT
 - Probation
 - Sexual health team
 - YOT
 - Other youth organisation
- (please state) _____

Internal

- Advice team
 - Counselling team
 - Sexual Health team
 - Drop-in team
 - Other (please state)
- _____

2.5 Relationship to client: _____

Date of referral: _____

2.6 What medication or intervention is being offered? (GP to complete)

2.7 Risk information:

- | | | | |
|-------------------|--------------------------|-----------------|--------------------------|
| Risk of self harm | <input type="checkbox"/> | Risk from abuse | <input type="checkbox"/> |
| Risk of suicide | <input type="checkbox"/> | Risk to others | <input type="checkbox"/> |
| Risk from neglect | <input type="checkbox"/> | | |

If yes to any of the above, please give further information:

2.8 Rating score (GP to complete if appropriate)

PHQ9..... GAD7.....

2.9 Is the young person taking any other prescribed medication currently?

Yes No *Please give details:* _____

2.10 Is this medication for:

- | | | | |
|-----------------------|--------------------------|--------------------|--------------------------|
| • Mental ill health | <input type="checkbox"/> | • Substance misuse | <input type="checkbox"/> |
| • Physical ill health | <input type="checkbox"/> | • Other | <input type="checkbox"/> |

SECTION 3: BACKGROUND INFORMATION ON YOUNG PERSON:

3.1 Presenting Problem (s):

- | | | | |
|-----------------------------------|--------------------------|--------------------------------|--------------------------|
| • Alcohol misuse | <input type="checkbox"/> | • Low mood | <input type="checkbox"/> |
| • Anxiety | <input type="checkbox"/> | • Low self esteem | <input type="checkbox"/> |
| • Asthma | <input type="checkbox"/> | • Obsessive-compulsive | <input type="checkbox"/> |
| • Backache | <input type="checkbox"/> | • Overdose | <input type="checkbox"/> |
| • Benefits | <input type="checkbox"/> | • Panic attacks | <input type="checkbox"/> |
| • Bereavement | <input type="checkbox"/> | • Phobia | <input type="checkbox"/> |
| • Bullying | <input type="checkbox"/> | • Physical abuse | <input type="checkbox"/> |
| • Communication difficulties | <input type="checkbox"/> | • Post-traumatic stress | <input type="checkbox"/> |
| • Cuts/breaks/bruises | <input type="checkbox"/> | • Pregnancy | <input type="checkbox"/> |
| • Debt problems | <input type="checkbox"/> | • Racism | <input type="checkbox"/> |
| • Depression | <input type="checkbox"/> | • Rape | <input type="checkbox"/> |
| • Difficult/ aggressive behaviour | <input type="checkbox"/> | • Relationship difficulties | <input type="checkbox"/> |
| • Discrimination | <input type="checkbox"/> | • Self harm | <input type="checkbox"/> |
| • Drug misuse | <input type="checkbox"/> | • Sexual abuse | <input type="checkbox"/> |
| • Ear infections | <input type="checkbox"/> | • Sexual transmitted infection | <input type="checkbox"/> |
| • Eating disorders | <input type="checkbox"/> | • Skin conditions | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|---------------------------|--------------------------|
| • Family problems | <input type="checkbox"/> | • Stomach upsets | <input type="checkbox"/> |
| • Harassment | <input type="checkbox"/> | • Stress | <input type="checkbox"/> |
| • Headaches | <input type="checkbox"/> | • Suicidal thoughts | <input type="checkbox"/> |
| • Housing problems | <input type="checkbox"/> | • Suicide attempts | <input type="checkbox"/> |
| • Identity issues (sexuality, gender, cultural) | <input type="checkbox"/> | • Unhappiness | <input type="checkbox"/> |
| • Isolation | <input type="checkbox"/> | • Victim of crime | <input type="checkbox"/> |
| • Lack of confidence | <input type="checkbox"/> | • Violence | <input type="checkbox"/> |
| • Lack of support | <input type="checkbox"/> | • Work/education problems | <input type="checkbox"/> |
| • Legal issues | <input type="checkbox"/> | • Other (please state) | <input type="checkbox"/> |
| • Loss/Grief | <input type="checkbox"/> | | |

3.2 Duration of current problem:

- 0-6 months 6 -12 months More than 12 months

3.3 Has there been previous contact with other services?

- | | | | |
|---|--------------------------|---|--------------------------|
| • No | <input type="checkbox"/> | • Housing department | <input type="checkbox"/> |
| • AMHS | <input type="checkbox"/> | • Housing support service (floating support) | <input type="checkbox"/> |
| • CAMHS | <input type="checkbox"/> | • In Care | <input type="checkbox"/> |
| • Child protection | <input type="checkbox"/> | • Probation | <input type="checkbox"/> |
| • Drug/alcohol service | <input type="checkbox"/> | • Social services | <input type="checkbox"/> |
| • Early intervention into Psychosis team | <input type="checkbox"/> | • Young offending teams | <input type="checkbox"/> |
| • GP/Nurse | <input type="checkbox"/> | • Other (please state) | <input type="checkbox"/> |

If yes please give details

3.4 Is there current contact with other services?

- | | | | |
|---|--------------------------|---|--------------------------|
| • No | <input type="checkbox"/> | • Housing department | <input type="checkbox"/> |
| • AMHS | <input type="checkbox"/> | • Housing support service (floating support) | <input type="checkbox"/> |
| • CAMHS | <input type="checkbox"/> | • In Care | <input type="checkbox"/> |
| • Child protection | <input type="checkbox"/> | • Probation | <input type="checkbox"/> |
| • Drug/alcohol service | <input type="checkbox"/> | • Social services | <input type="checkbox"/> |
| • Early intervention into Psychosis team | <input type="checkbox"/> | • Young offending teams | <input type="checkbox"/> |
| • GP/Nurse | <input type="checkbox"/> | • Other (please state) | <input type="checkbox"/> |

If yes please give the name and telephone of the service/worker

3.5 Is the young person currently using drugs? If yes, how often?

- Amphetamines No Daily Weekly Monthly Occasionally
- Benzos No Daily Weekly Monthly Occasionally
- Cannabis/skunk No Daily Weekly Monthly Occasionally
- Cigarettes No Daily Weekly Monthly Occasionally
- Cocaine No Daily Weekly Monthly Occasionally
- Crack No Daily Weekly Monthly Occasionally
- Heroin No Daily Weekly Monthly Occasionally
- MDMA No Daily Weekly Monthly Occasionally
- Parental Use No Daily Weekly Monthly Occasionally
- Poly Use No Daily Weekly Monthly Occasionally
- Solvents No Daily Weekly Monthly Occasionally
- Other _____ No Daily Weekly Monthly Occasionally
- Prefer not to say

3.6 Is the young person currently using alcohol? If yes, how often?

- Alcohol pops No Daily Weekly Monthly Occasionally
- Beer No Daily Weekly Monthly Occasionally
- Cider No Daily Weekly Monthly Occasionally
- Sprints No Daily Weekly Monthly Occasionally
- Wine No Daily Weekly Monthly Occasionally
- Other _____ No Daily Weekly Monthly Occasionally
- Prefer not to say

Consent statement for information storage and information sharing“

We need to collect the information in this form so that we can understand what help you may need. If we cannot cover all of your needs we may need to share some of this information with the other organisations, we will tell you who, so that they can help us to provide the services you need. If we need to share information with any other organisation(s) later to offer you more help we will ask you about this before we do it.

We will treat your information as confidential and we will not share it with any other organisation unless we are required by law to share it or unless you will come to some harm if we do not share it. In any case we will only ever share the minimum information we need to share.

Yes **No** I understand the information that is recorded on this form and that it will be stored and used for the purpose of providing services to me.

Yes **No** I have had the reasons for information sharing explained to me and I understand those reasons.

Yes **No** I agree to the sharing of information as and when necessary.

Signed.....Name.....Date.....

TO BE COMPLETED BY YASP:

Name of worker: _____

Action taken:

- Referred to GP/Nurse
- Referred to Counselling team
- Referred to advice team
- Referral not appropriate, referred to other service

(please give details _____)

Date of initial counselling assessment _____

Date of initial advice interview/assessment _____

Start date: _____

End Date: _____

Intervention offered:

- Number of counselling sessions and type
(Please give details _____)

- Number of GP/Nurse sessions and type
(Please give details _____)

- Number of advice sessions and type
(Please give details _____)

Number of sessions attended:

- Counselling sessions _____

- GP/Nurse sessions _____

- Advice sessions _____