FOR OFFICE USE ONLY

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| DATE RECEIVED: | DATE BOXALL SENT: | DATE ALLOCATED: |

**Outreach Referral Form**

|  |  |  |  |  |  |
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| Outreach |  | Protective Behaviours |  | Drawing & Talking |  |
| Mindfulness |  | Counselling  |  | Mental Health Worker |  |
| Advice & Strategies  |  | Transition SupportKS1-2, KS2-3Please specify schools if known  |  |
| Other, please specify |  |

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| **Student** |
| Surname |  | Forenames |  |
| Gender |  | Date of Birth |  | Year group |  | % Attendance |  |

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| **Who is referring?** |
| School | Contact Name | Position |
|  |  |  |
| Contact Number | Email Address | Date |
|  |  |  |

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| **What is the main reason for the referrral?** |  |

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| **Student’s details** |
| Primary address | Secondary address |
|  |  |
| Postcode:  |  | Postcode:  |  |
| Behaviour points |  | Achievement points |  | Number of days lost to exclusion |  |
| **Does the student receive …** |
| Free school meals ? |  | Pupil premium? |  | 1:1 support? |  | ENF (yes/no)? |  | If yes, start date. |  |
| Is this a Child Looked After? |  | CP/CIN |  | EHCP (Yes/No/In progress) ? | **……** | EHM/TAF? |  |
| Previous DESC intervention? |
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| **Parent/carer details** |
| Full name: | Address:(if different from the young person) | DOB | Gender | Parental responsibility | First language: |
|  |  |  |  |  |  |
| Contact Number 1 | Contact number 2 | Email |
|  |  |  |
| Full name: | Address:(if different from the young person) | DOB | Gender | Parental responsibility | First language: |
|  |  |  |  |  |  |
| Contact Number 1 | Contact number 2 | Email |
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| **Family composition/significant others** |
| Full name  | Address, Postcode, and Tel  | DOB if known  | Relationship to young person named overleaf  |
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| **Who is working with the young person/family?** |
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|  | Y/N | Active (Y/N) | Worker / Contact Details |
| CAMHS |  |  |  |
| EP |  |  |  |
| Social Worker |  |  |  |
| Intensive Families First |  |  |  |
| Family Support Worker |  |  |  |
| Attendance Officer |  |  |  |
| Other (please list)e.g. Gade Family Services/Woodfield.CAT |  |  |  |

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| **Please complete this section if an EHM has been completed** |
| On this young person (Y/N) |  | Date: |  |
| On another young person in the Family/Household (Y/N)  |  | Date: |  |
| Is the EHM active? (Yes/No)  |  |
| Name of Lead Professional: |  | Email: |  |

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| **Academic history** |
| Schools | From | To | Reason for move |
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| **Exclusions this academic year (please give details of fixed term exclusions).** |
| Date | Reasons for exclusion | Fixed Term (days) | Permanent |
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| What are the desired outcomes? |  |
| Strengths: |  |

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| **What school based action has been taken to reduce the behaviours causing concern?** |
|  | Behaviour | Support | Outcome |
| Tier 1 |  |  |  |
| Tier 2 |  |  |  |

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| PSP  | DETAILS:  |
| Risk Management Plan | DETAILS:  |

**Additional information (if required).**

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| **Permissions** |
| Name: | Relationship to young person: | Signature: | Date: |
|  |  |  |  |
| Young person signature: | Comments: |
|  |  |

Please return to either referrals@desc.herts.sch.uk or by post to:

**Referrals Administration**

**30 Tenzing Road
Hemel Hempstead
Hertfordshire
HP2 4HS**