**St Giles Trust Referral Form**

**SOS+ North Yorkshire**

**Please return referral forms to:** **northyorkshireSOSplus@stgilestrust.org.uk**

|  |  |
| --- | --- |
| **Date of referral:** |  |
| **Name of referrer and Agency:** |  |
| **Contact details:****Email:****Telephone number:** |  |
| **Is young person aware of referral?****Have they consented?**  | **Yes / No** **Yes / No**  |
| **Are the Young Persons family aware of referral?**  |  |
| **Social Worker (if applicable) and contact details:**  |  |

|  |
| --- |
| **Details of person being referred:** |
| **Name:**Preferred name:Aliases: | **Address:****Post Code:**Accommodation Type:Able to return to this address? |
| **Date of Birth:** | Age: |
| **Ethnicity:** |
| **Gender:** | **Contact Number:** |
| **Sexual Orientation:** | **E-mail:** |
| **Do they consider themselves disabled? Y/N** **If yes, Please provide details:**  | **Parent/Guardian:** |
| **Relationship:** |
|  | **Contact Number:** |
|  | **E-Mail**: |

|  |  |
| --- | --- |
| **Known to Agencies: Yes / No** **Agencies known to:**  | **GP registered? Yes / No** **GP Name and Address:** |
| **Current gang affiliation if applicable:** | **MISPERS/ABSENCES:** |
|  |  |
| **Current or pending offences:** | **Previous cautions/ convictions:** |
|  |  |

|  |
| --- |
| **Immediate risk, exploitation, vulnerability assessment:**(Complete for referrals where no PNN submitted) |
| **Suicide/ Self-harm/Neglect:**  | Y/N |
|  |
| **Substance misuse:** *(List each substance)* | Y/N |
|  |
| **Physical Health/ Mental Health/ Disability:** *(list each condition)* | Y/N |
|  |
| **Human Slavery:** | Y/N |
|  |
| **Arson/Damage to property:** | Y/N |
|  |
| **Sexual Offences:** | Y/N |
|  |
| **Violent Offences:** | Y/N |
|  |
| **Females:** *(workers/community)* | Y/N |
|  |
| **Males:** *(worker/Community)* | Y/N |
|  |
| **Children:** | Y/N |
|  |
| **Concerns around Serious Youth Violence:** | Y/N |
|  |
| **Concerns around Child Criminal Exploitation/Serious Organised Crime:** | Y/N |
|  |
| **Concerns of Radicalisation/Extremism:** | Y/N |
|  |
| **Other agencies involved with client (Please list and provide contact details):** | Y/N |
|  |

|  |
| --- |
| **Support Needs** |
| **Language Issues:** |
|  |
| **Drug:** *(type/amount/frequency/length of use/route)* |
|  |
| **Alcohol:** *(type/amount/frequency)* |
|  |
| **Physical Health/Mental Health/Disability:** *(diagnosis/medication/care)* |
|  |
| **Education/Training:** |
|  |
| **Finances/Benefits/Debt:** |
|  |
| **Family Relationships:** |
|  |
| **Attitudes, thinking and behaviours:** |
|  |
| **Exploitation or Violence:** |
|  |
| **Accommodation**:  |
|  |
| **Any other relevant information:**  |

**Please return referral forms to: northyorkshireSOSplus@stgilestrust.org.uk**