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**CONFIDENTIAL SISTER SYSTEM ‘PROFESSIONAL’S REFERRAL FORM’**

**Sister System:** Studio 31, The Trampery, 639 High Road, London, N17 8AA

**Email:** [referrals@sistersystem.org](mailto:referrals@sistersystem.org)

**Telephone:** 07763 008018

**Web:** [www.sistersystem.org](http://www.sistersystem.org)

All referrals must be made with the consent of the Young Person. This form will be held in confidence but may be shown to the Young Person if requested. For this referral to be processed it is essential that all sections are completed in full.

Have you discussed this referral with the Young Person and are they in agreement with you making the referral to Sister System? **YES**  / **NO**

We may need to contact you for further information or clarification to help us to assess the referral properly.

**We unable to accept referrals for Girls/Young Women who fall under any of the risks listed below:**

* Weapon use or carrying weapons.
* Known class A drug use/dependency.
* Severe alcohol dependency/abuse.
* High levels of mental health challenges such as, hospitalised suicide attempts, episodes of psychosis or multiple personality disorder.

## **Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Young Person:** |  | **DOB:** |  |
|  |  |  |  |
| **Referral date:** |  | **Address:** | **Postcode:** |
|  |  |  |  |
| **Contact Telephone Number:** | (Name/relationship if Young Person cannot be contacted)  Has this person permitted to being contacted? YES  / NO | **Disability or additional learning needs:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **E-mail:** |  | **Ethnicity and religion:** |  |
|  |  |  |  |
| **Languages spoken:** |  | **Pronouns:** |  |

**Care Plan:**

**Child Protection Plan**  **Child in Need Plan**  **Care order Plan**  **EHCP**

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| --- |
| **Additional information:** |

## **Parent/Carer/Guardian’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of household member with caring responsibilities for the Young Person:** | | | |
|  |  |  |  |
| **Parent/Carer/Guardian’s name:** |  | **Gender:** |  |
|  |  |  |  |
| **Languages spoken:** |  | **Ethnicity:** |  |
|  |  |  |  |
| **Contact telephone number:** |  | **Email:** |  |

## **Referrer’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer’s name and role:** |  | **Contact details** |  |
|  |  |  |  |
| **How long has the Young Person been involved with your agency and what work has been carried out?** |  | **Agency details and address:** |  |
|  |  |  |  |

## **Key Information**

|  |  |  |
| --- | --- | --- |
| **Young Person’s place of Residence:** | | |
| **Independent Accommodation** | **Family Home** | **Children’s Home** |
|  |  |  |
| **Semi-independent accommodation** | **Foster Care** | **Other:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please give details of any other agencies currently working with this Young Person:** | | | | | | |
| **Agency** | **Lead Person** | | **Email Address** | | | **Phone Number** |
|  |  | |  | | |  |
|  |  | |  | | |  |
|  |  | |  | | |  |
| **Family Doctor Details** (Essential information to follow safeguarding protocol and referral to external mental health providers) | | | | | | |
| **Name and Address:** | |  | | **Phone Number:** |  | |

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| **Please note here the relevant history related to the Young Person:** |
|  |

## **Young Person’s Needs**

**Please respond to the following questions thoroughly so that we can assess and provide the most appropriate support in a timely manor:**

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| --- |
| The current risks that the Young Person may be experiencing:  Any risk that the Young Person may be posing to others: |

**Desired outcomes for Young Person’s involvement with Sister System:**

|  |
| --- |
| What do you hope to achieve from the Young Person undertaking work with Sister System?  What would the Young Person hope to achieve from undertaking the work with Sister System? |

## **Signature & Declaration**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer’s Name:** |  | **Signature:** |  | **Date:** |  |
|  |  |  |  |  |  |
| **Young Person Name:** |  | **Signature:** |  | **Date:** |  |

|  |
| --- |
| Thank you for taking time to provide this information which will help us to process the referral.  Please note, and advise the Young Person:   * We are unable to process your referral until we have received this form. * We will try to respond to all referrals within 2 weeks of receipt. * Once we have assessed that the referral is likely to meet our criteria, we will contact the Young Person to have an initial conversation with them and to plan the next steps. * When we begin to work with the Young Person, we will remain in touch with you about supporting this Young Person and will contact you when our support ends.   **If you have any queries at any time, please contact Danny White, Programmes Manager and Designated Safeguarding Lead at programmes@sistersystem.org or email referrals@sistersystem.org** |