|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Section 1: Child or Young Person’s Details | | | | |
| **Surname:** | | **ID No.** | | Soscare |
| **Forename:** | |
| **Known As:** | | **HCN:** | | |
| **Address:** | | **Previous Address:** | | |
| **Postcode:** | |  | | |
| **Telephone No:** | | **Previous Postcode:** | |  |
| **Mobile No:** | | **Locality:** | | 1=BT – Belfast Central |
| **Date of Birth:** | | **Gender** | | Male |
| **GP Name:** | | **GP Tel No:** | | |
| **GP Address:** | | **GP Email Address:** | | |
| **GP Postcode:** | |  | | |
| **School Name:** | | **School Tel No:** | | |
| **School Address:** | | **School Postcode:** | | |
| **Does the Child have a Disability?** Yes | **If Yes, What Disability:**  (& source of diagnosis) | | **Other Special Needs:** | |
| **Nationality:** | 1=Austrian | **Ethnic Origin:** | | B=Bangladeshi |
| **Religion:** | 1=Church of Ireland | **Country of Origin:** | | AAFG=AFGHANISTAN |
| **Language Spoken:** | 1=Albanian | **Communication Support:** | | Yes |
| **Interpreter**  **Signer**  **Document Translator** | | | | |

|  |  |
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| **Section 2a: Referrer’s Details** | |
| **Name of Referrer:** | **Designation:** |
| **Address:** | **Date of Referral:**11/05/2015 |
| **Postcode:** | **Contact Details:** |
| **Section 2b: Reason for Referral** | |
|  | |
| **Section 2c: Immediate Actions** | |
| **Are Immediate /Actions necessary to safeguard the child(ren) or young person(s)?** | Yes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section 3a: Primary Carers & Other Household Members (Incl. non-family members)** | | | | |
|  | **Member 1** | **Member 2** | **Member 3** | **Member 4** |
| **Last Name:** |  |  |  |  |
| **Alternative Last Name:** |  |  |  |  |
| **First Name:** |  |  |  |  |
| **Telephone No:** |  |  |  |  |
| **Mobile No:** |  |  |  |  |
| **Date of Birth:** |  |  |  |  |
| **Relationship to Child/ YP:** |  |  |  |  |
| **Language Spoken:** | 1=Albanian | 2=Arabic | 3=Bengali | 4=British Sign Language |
| **Nationality:** | 1=Austrian | 2=Belgian | 3=British | 4=Bulgarian |
| **Communication Support:** | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details |
| **Section 3b: Significant Others (Incl. family members who are not members of the child(ren) or young person(s) household)** | | | | |
|  | **Other 1** | **Other 2** | **Other 3** | **Other 4** |
| **Last Name:** |  |  |  |  |
| **Alternative Last Name:** |  |  |  |  |
| **First Name:** |  |  |  |  |
| **Address:** |  |  |  |  |
| **Postcode:** |  |  |  |  |
| **Mobile No:** |  |  |  |  |
| **Date of Birth:** |  |  |  |  |
| **Relationship to Child/ YP:** |  |  |  |  |
| **Language Spoken:** | 1=Albanian | 2=Arabic | 3=Bengali | 4=British Sign Language |
| **Nationality:** | 1=Austrian | 2=Belgian | 3=British | 4=Bulgarian |
| **Communication Support:** | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details | Interpreter  Signer  Doc. Trans  Details |

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| **Section 4a: Summary of Referrer’s Previous Involvement** | |
|  | |
| **Section 4b: Referral Consent** | |
| **Child(ren) / Young Person(s)** | |
| **Are all the children in the family aware the referral is being made?** | Yes  No |
| **Do all the children in the family consent to the Referral being made?** | Yes  No |
| **If NO, please explain** | |
| **Parent/ Carer** | |
| **Are Parents/ Carers of all the children/ young people are Referral has been made?** | Yes  No |
| **Do they consent to the Referral being made?** | Yes  No |
| **If NO, please explain** | |

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| **Section 5: Additional Information: Agencies Currently Working with Child or Young Person** |
| **Agency and Contact Details** |
| **Health Professional:** |
| **Name:** |
| **Role:** |
| **Tel No:** |
| **Email:** |
| **Health Professional:** |
| **Name:** |
| **Role:** |
| **Tel No:** |
| **Email:** |
| **Health Professional:** |
| **Name:** |
| **Role:** |
| **Tel No:** |
| **Email:** |
| **Health Professional:** |
| **Name:** |
| **Role:** |
| **Tel No:** |
| **Email:** |