Young People's Independent Sexual Violence Advisor (YPISVA) Referral Form

Please email completed referrals to: isva.isva@hamptontrust.cjsm.net

DATE:

SECTION 1 – YOUNG PERSON DETAILS

Forename		**Surname**	
Also known as		**Date of Birth**	
Gender			
Address at which the child/young person is currently living			**Landline / home telephone number:** **Email Address:**
Child/young person mobile number		**Parent's/Carer's mobile number**	

Is the Child / Young Person: (tick all that apply) –		
☐ Living with parents	☐ Living with relatives	☐ Other (please state)
☐ Looked After Child	☐ Subject to a Child Protection Plan	☐ Adopted

First language:	Interpreter required? ☐ Yes ☐ No If yes, which language?
Does the child/young person consider themselves to be transgender? ☐ Yes ☐ No	Sexual orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Prefer not to say

Does the child / young person have a disability? ☐ Yes ☐ No If Yes, please specify:	Does the child / young person have a Visual impairment ☐ Yes ☐ No Hearing impairment ☐ Yes ☐ No	Is the child / young person a Young Carer? ☐ Yes ☐ No

Name of GP		**GP surgery name**	
GP surgery telephone number and email address		GP surgery address:	

Ethnicity	☐ White British	☐ Irish	☐ Gypsy or Irish Traveller
	☐ White and Black Caribbean	☐ White and Black African	☐ White and Asian

☐ Indian	☐ Pakistani	☐ Chinese	☐ Bangladeshi
☐ Any other Asian background	☐ African	☐ Caribbean	☐ Other Black/Caribbean/African Background
☐ Arab	☐ Any other ethnic group – please state		
	☐ Any other mixed / multiple ethnic background – please state		

Religion	☐ Agnostic ☐ Atheist ☐ Baha'I ☐ Buddhist ☐ Chinese (Taoist / Confucian) ☐ Christian ☐ Hindu ☐ Humanist ☐ Japanese (Shinto) ☐ Jewish ☐ Jainism ☐ Muslim ☐ Pagan ☐ Rastafarian ☐ Sikh ☐ Spiritualist ☐ Do not wish to disclose ☐ Other

SECTION 2 – PARENT/CARER DETAILS

Who holds parental responsibility for the child /young person?

Forename		Surname	
Relationship		Telephone number:	
Address			

Is there any history of parental mental health difficulties and/or history of substance misuse? □ Yes □ No

If yes, please provide details:

Is there any history of domestic violence within the family? □ Yes □ No

If yes, please provide details:

Are there any adult services currently involved? □ Yes □ No

If yes, please provide details:

SECTION 3 – CHILDREN'S SERVICES

Name of Allocated Social Worker or Family Support Worker	
Children's Services Team	

Address	
Telephone	

SECTION 4 - EDUCATION

Name of School/College:	School/College address and telephone number:
Home school / Tutor	Please give details:

SECTION 5 – PRESENTING ISSUES, RISK AND CONCERNS

Please state any mental health difficulties, onset, frequency and duration, current presenting risk, details of any self harming behaviours, suicidal ideation/intent, interventions tried, impact on child and family, impact on education, and any relevant medical history:

What services have been accessed already?

Is this support ongoing?

Is the young person on any current medication? □ Yes □ No If Yes, please provide details:

Are there any concerns relating to substance misuse? □ Yes □ No If Yes, please provide details:

Are there any concerns relating to food/weight/suspected eating disorder? □ Yes □ No If Yes, please provide details:

SECTION 6 - REASON FOR REFERRAL

Sexual abuse/violence □ Yes □ No **Sexual Exploitation** □ Yes □ No Please full provide details
Historic: □ Yes □ No **Recent**: □ Yes □ No

Perpetrators Home □ Yes □ No Victims Home □ Yes □ No Entertainment Venue □ Yes □ No Outdoors □ Yes □ No

Transportation □ Yes □ No Workplace □ Yes □ No Public Building □ Yes □ No Other □ Yes □ No

Reported to police □ Yes □ No **RMS Number:**

Officer Name:

Officer Contact details:

Mobile: **Email:**

Any other relevant details of case:

SECTION 7 – REFERRER DETAILS

Name		Job Title/Profession:	
Address			
Post Code:		Telephone:	
Date of Referral		Email address	

SECTION 8 – Referral Consent

			If no, please give reason
Does the Parent/Carer know about the referral?	Yes	No	
Does the Parent/Carer consent to the referral?	Yes	No	
Does the Child/Young Person know about the referral?	Yes	No	
Does the Child/Young Person consent to the referral?	Yes	No	
Does the Child/Young Person want YPISVA support	Yes	No	
Who should be our main contact (please delete as appropriate)	Young person	Parent/Carer	Other Details:
Preferred method of contact	Phone	Email	Post

SECTION 9 - FOR OFFICE USE ONLY

Received:	Date:

Allocated:	Date:
Sign posting:	

Please send referral to secure email: isva.isva@hamptontrust.cjsm.net

Any Queries please email: isva@hamptontrust.org.uk