**CHILDREN’S GROUP PROGRAMME**

**REFERRAL FORM**

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| **A free 6 week structured therapeutic group programme for children aged 11-15 years old who have been affected by domestic and/or sexual violence.**  Please return this form to  Leanne Higgins  Email: [l.higgins:solacewomensaid.org](mailto:k.shayler@solacewomensaid.org)  Phone: : 0203 874 5003/ 07483014561 ( I only work Thursday & Fridays)  **Please note that in order to access this programme, separation must have occurred and the perpetrating adult must not be living in the family home.** |

**Child’s details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s name and address** | **D.O.B** | **Sex** | **Ethnicity & religion** | **Disability**  **(illness, impairment, allergies)** | **Sexual orientation (if known)** |
|  |  |  |  |  |  |

**Mother’s details ( Throughout this referral form, the term mother refers to female carers also)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mother’s name** | **D.O.B** | **Ethnicity & religion** | **Main language spoken** | **Disability** | **Sexual orientation (if known)** |
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| --- | --- |
| **Mother’s address** |  |
| **Mobile telephone number** |  |
| **Is it safe to contact mother by phone? If not, what is the best way to contact her?** |  |

**FAMILY HISTORY AND ADDITIONAL RELEVANT INFORMATION**

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| **Please indicate the types of abuse and violence that the family experienced**   * Physical abuse * Emotional abuse * Financial abuse * Sexual abuse and exploitation * Forced marriage * Honour based violence * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Has the child/ young person experienced or witnessed?**  Physical abuse Yes ⬜ No ⬜  Sexual abuse Yes ⬜ No ⬜  Emotional abuse Yes ⬜ No ⬜  Verbal abuse Yes ⬜ No ⬜ |

**PLEASE INDICATE ANY CURRENT ISSUES AND SUPPORT NEEDS FOR THE CHILD REFERRED**

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| * Emotional problems * Behavioural problems * Not progressing at school * Lack of friends ( social isolation) * Lack of interest in afterschool activities * At risk of offending/ involvement with crime * Has nightmares or disturbed sleep * Suffers because of separated parents * Has suffered a loss or bereavement of any kind * Is withdrawn or continually unhappy * Child in care/adopted * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What does the mother want her children to achieve by participating in the group?** |

**DETAILS OF SIBLING(S)**

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| --- | --- | --- |
| **Name** | **Surname (if different)** | **D.O.B** |
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| **Name of agencies or other professionals involved (include Social Worker, Cafcass reporter, YOT, Guardian, Learning Mentor etc.)** | | |
| **Name and Job Title** | **Telephone** | **Email** |
| **Name and Job Title** | **Telephone** | **Email** |
| **Name and Job Title** | **Telephone** | **Email** |
| **Where did you hear about this programme?** | | |

**REFERRAL AGENCY DETAILS. Please provide full details to enable us to contact you.**

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| --- | --- |
| **Name and Job Title** | **Agency** |
| **Address** | **Telephone number**  **Email** |

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| For administrative use only: Date Received………………………………  ....................................................................  Call to offer Group …………………………………………….  Pre-Group interview date ..............…………………………………….  Post-Group interview date ……………………………………………..  Transport arrangements ……………………………………………..  Referral deferred / not accepted  Referee contacted ……………………………………………. |