**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 toLeanne HigginsEmail: l.higgins:solacewomensaid.orgPhone: : 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)**  |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| **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* Is withdrawn or continually unhappy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)**

|  |  |  |
| --- | --- | --- |
| **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.**

|  |  |
| --- | --- |
| **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 ……………………………………………. |