CYP Mental Health & Bereavement Support Referral Form

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| 1. **Please choose which service you require** | | | | | | | | |
| My Time emotional wellbeing support  **Please complete section 3**  My Time offers an early intervention peer support service to help children & young people aged 5-19 cope with emotional wellbeing, anxiety, anger or separation. | | | | | | Dragonflies Bereavement support  **Please complete section 4**  Dragonflies offers free support to children aged 5-18 years old and their families who are experiencing bereavement. | | |
| 1. **Please complete for all referrals** | | | | | | | | |
| Date of referral: |  | | | | | | Re-referral? Y / N | |
| Initial contact date:  (complete by FSN Admin) | | | PR Number:  (completed by FSN Admin) | | | | | |
| Child / Young person’s name: | | | | | | | | |
| DOB: | | Age: | | | | | Gender: | |
| Main Parent / Carer Name: |  | | | | | 2nd Parent / Carer Name: |  | |
| Address: |  | | | | | Address: |  | |
| Post Code: |  | | | | | Post Code: |  | |
| Tel No 1: |  | | | | | Tel No 1: |  | |
| Tel No 2: |  | | | | | Tel No 2: |  | |
| Email: |  | | | | | Email: |  | |
| CYP contact number: |  | | | | | CYP email: |  | |
| Does the family consent for this referral? Y / N | | | | | | | | |
| School Attended: | | | | | | | School Year: | |
| Parental permission to contact school and other agencies, if applicable: Y / N | | | | | | | | |
| Any other agencies involved (give contact details where possible): | | | | | | | | |
| Name of referring organisation: | | | | | | Name of referring person: | | |
| Referrer’s telephone number: | | | | | | Referrer’s email address: | | |
| 1. **My Time – Emotional Wellbeing Support referrals only** | | | | | | | | |
| Reason for Referral: (tick all that apply) | | | | | | | | |
| Anxiety | Low Mood | | | Anger Issues | | | Low self-esteem | |
| Risky behaviour | Bullying | | | Communication & Social Issues | | | | |
| Other – please specify: |  | | | | | | | |
| 1. **Dragonflies Bereavement Support referrals only** | | | | | | | | |
| **Date of death** |  | | | | **Cause of death** | | |  |
| **Relationship to child** |  | | | | **Was this person one of the child’s main carers?** | | | **Yes / No** |
| **Life changes for the child/YP since the death (tick all that apply)** | | | | | | | | |
|  Main carer newly alone after death of partner   New main carer   Parental separation or divorce   New step-parent   New sibling(s) or step-sibling(s)   House move   Change of school (apart from usual transitions)   Move into foster/residential care   Loss of contact with family members   Loss of contact with friends | | | | | | | | |
| 1. **– Please complete for all referrals** | | | | | | | | |
| **Safeguarding Issues?**  (CP/LAC/etc.) | | | | | | | | |
| **Current risks?**  (self-harm/ suicidal thoughts/risky behaviour) | | | | | | | | |
| **Referral information:**  Please include all relevant information such as family/living situations, presenting issue(s), cause (if known), timeframe, and the impact on the young person’s life | | | | | | | | |
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Please return form to:

Children’s and Young People’s Services, FSN St Nicholas Centre, 66 London Road, St Leonard’s on Sea, East Sussex, TN37 6AS

Tel: 01424 377123/377124

Email: [enquiriescyp@fsncharity.co.uk](mailto:enquiriescyp@fsncharity.co.uk)

Registered Charity Number: 208446