**Traded Service**

**Traded Referral Form**

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| **SCHOOL NAME:** |
| **Which service are you requesting?** |
| **Counselling** [ ] **School Transition Workshops** [ ] **Small Group Pupil Programme** [ ]  | **Mentoring** [ ] **Bespoke Parenting Workshop** [ ] **Penn Resilience** [ ]  | **Behaviour Support** [ ] **Other (Please specify)** [ ]  |

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| **Student’s Details** |
| Name:       | Date of Birth:       Age:      |
| Address:      | Year Group:       |
| Gender: Male [ ]  Female [ ]  Other: [ ]  |
| Ethnicity:       |
| Religion:       |
| Disability:      |
| First Language:      |

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| **Parent/ Carers Details** |
| Name:       | Gender: Male [ ]  Female [ ]   |
| Address (If different from Child):      | Contact Number:      |
| Email:       |
| Religion:       |
| Parental Responsibility: Yes[ ]  No [ ]  | Ethnicity:      |
| First Language:      | Disability:       |

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| **Significant Others/ Siblings**  |
| **Name:**  | **Address:** | **School:** | **DOB**  | **Relationship to Child:** | **Gender** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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| **School Details** |
| School Contact (Referrers) Name:      | Contact Phone Number:      |
| Contact Email:      | Pupil UPN:      |
| What is the reason for your referral?Please outline your concerns: |
|       |

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| **What is the need for the student?** |
| ADHD/ ASD/ SEND [ ] Attendance/School Refuser [ ] Domestic Abuse [ ] Educational Needs [ ] Mental Health/ Emotional Wellbeing [ ] Family Relationships [ ] Finance [ ] Parenting [ ]  | Health/Medical- Child [ ] Health/ Medical- Parent [ ] Housing [ ] Safeguarding [ ] Risk of Exclusion [ ] Worklessness [ ] Substance Misuse- Child [ ] Substance Misuse- Parent [ ]  | School Transition [ ] Young Carer [ ] School Refusal [ ] LGBTQ+ [ ] Unknown/Other [ ]  |

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| **Primary Need:** |
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| **Secondary Need:** |
|       |

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| **Other services involved with the child/family** |
| **Name of Organisation**  | **Contact Name**  | **Contact Number / Email** | **Details of service carried out with child/ family** |
|       |       |            |       |
|       |       |            |       |
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| **Additional Information** |
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| **Consent** |

Consent and Information sharing – Parent consent is required to enable information sharing with the identified service. Young people should be aware of the request for a service and be asked for their consent. You will need to make a professional judgement about the young person’s understanding of giving consent. St Albans Plus is part of the Families First Early Help Module.

* I understand that the information contained in this form will be shared with The St Albans Plus Schools Partnership and Families First Early Help.
* I agree to the request and give consent for the service to work with my child/ren and/or me as parent/carer.
* I understand I can withdraw consent at any time.

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| Name of person making the intervention request (referral)  |       |
| Signature of person making the intervention request |       Date:      |
| Parent/ Carer Name  |        |
| Parent/ Carer Signature |       Date:      |

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| If consent has not been obtained, please give a reason:      |

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| Please return this form to: |
| **Post:**Karen BroomVista St Albans CICLeadership House, St Albans Girls School, Sandridgebury Lane, St Albans, AL3 6DB | **Email:**referrals@vistastalbans.org.uk |

For help and assistance filling out this form please contact the Vista Office on: **01727 519 128**

All Vista St Albans and St Albans Plus staff are DBS checked and attend regular safeguarding training as well as their relevant qualifications.

Vista is GDPR compliant. Our ICO registration number is ZA354653.