**Student Support Referral Form**

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| **SCHOOL NAME:** |
| **Which service are you requesting?** |
| **Mentoring** [ ]  | **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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| **Consent** |

Consent and Information sharing – Parent/Carer 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.**

I have read and agree with the information on the referral and understand that the information contained in this form will be shared with Vista St Albans and Families First Early Help.

* I agree to the request and give consent for Student Support Yes [ ]  No [ ]
* I agree for Vista St Albans to work with my child Yes [ ]  No [ ]
* I understand I can withdraw consent at any time. Yes [ ]  No [ ]
* I understand that Vista staff follow Hertfordshire Safeguarding procedures and should a

disclosure be made it will be passed to the relevant Designated Safeguarding Lead. Yes [ ]  No [ ]

**VISTA staff reserve the right to withdraw from the service/ end the session should inappropriate behaviour be displayed.**

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

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| Please email this completed form to: **referrals@vistastalbans.org.uk****The form must be completed in a Word Document- Only the signed consent page is to be scanned separately.****For help and assistance filling out this form please call: 01727 519128** |

All Vista St Albans 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.