Hear Our Voice
Referral Form

The information contained on this form is **confidential** and should not be shared without the consent of HOV and the Young Person/family concerned.

***This form should be completed <u>by or with</u> the young person and will be shared with them**

<u>Your Details:</u> Name: Date of Birth: Age: Gender: Ethnicity:	Home Address: Tel/ mobile: Email: How should we contact you? – email/text/phone/letter Can we contact your parents/carers? Y/N
Can we make contact at your home address? Y/N	If not is there an alternative address?
<u>Your Parent/Carer Details (if under 18):</u> Name: Tel: Relationship to you:	**<u>Your Emergency Contact details (if different):</u>** Name: Tel: Relationship to you:
<u>Referrer Details:</u> Name: Agency: Contact:	**<u>GP Details:</u>** Name/Surgery: Address: Tel:
Do you work with any other agencies (eg. social worker, youth worker, family worker, CAMHS, counselling)? Name (s) and organisation:	
Is it OK for us to contact these agencies? (state which)	
What school/college do you attend (if any)?	
Do you know if you have a CAF/TAC in place? Y/N	
If under 18 have your parent/carers consented to this referral? Y/N	
Are you happy for us to share your information with other projects in our partnership (Young People Cornwall and Kooth Counselling)? Y/N	

Please return this form to Ellie Wright -
Email: elliew@ypc.org.uk
Tel: 01872 222447/ 07949 992768

Postal Address:
HOV, Young People Cornwall
61 Lemon Street, Truro TR1 2PE

The following questions are designed to help us understand your situation and make sure we offer you the right support. Please answer as fully as you feel you can.

What support would you like from Hear Our Voice? ***(please tick all that apply)***

- One to one support *(for mental health and emotional wellbeing)*
- Information and support to access specialist services
- Group work *(small social groups – activities, workshops and mental health awareness)*
- Participation – getting your voice heard and influencing services.

What is the <u>main</u> reason you are referring to us and how is this affecting your daily life?

Who do you live with?

What support (if any) has already been put in place for you (at school/home for example)?

Please tell us anything else you think we should know:

Please tick any of the following that apply to you:	If you have ticked yes to any of these please give us a bit more information:
Young Carer ☐ In Care ☐ Care leaver ☐ Disability ☐ Learning Need ☐ Medical Condition ☐ ASD/ ADHD ☐	

I agree to this referral ☐
I agree to information sharing with partner agencies ☐
I agree to secure storage of my personal details ☐
(please see attached information leaflet)

Young person's signature: **Date:**

Office use only:

Date received:

RR: