Service Six

Initial Contact & Referral Form

Confidentiality and this form

This form and the information contained within will be used to assess appropriate services and actions. The information provided will be kept confidentially and securely within Service Six and shared as appropriate between Service Six personnel, with the exception of any circumstances which require us to breach that confidentiality under the terms of our confidentiality policy, a copy of which is available on request or on our website www.servicesix.co.uk. An example of such circumstances would be where we ascertain that a child is in immediate significant harm.

Referral Agency & Individual Details			
Name of Person Making Referral			
Job Title of Person Making Referral			
Referral Agency Name			
Referral Agency Address			
Line 1			
Town			
Postcode		Referral Agency Tel. Number	
Referral Agency Email			
Referral Agency Authorised Signature			
If you are completing this form digitally and do not have a digital signature please tick this box to authorize (We reserve the right to authenticate the information contained within and the authorised signature substitute)			
Referral Agency Authorised Name			

Potential Client Details							
Name				Gender			
D.O.B.		Age		Ethnicity		Disability	
Address Line 1							
Line 2							
Town				Postcode			
Telephone Number				Mobile Number			
Email Address							
Who can we speak to at home re the referral?							
Who can we **NOT** speak to at home re the referral?							
Are you in?	education	training	employment	unemployed	retired		
other (please state)							

School details or other such similar agency or project (for children & young people referral ONLY)			
Name		Tel No	
Email			
Address Line 1			
Line 2			
Town		Postcode	
Is the School / Agency Aware of the Referral?	YES NO		
Is the Client Aware of the Referral?	YES NO		
Teacher / Identified Person Contact Name			
Teacher / Identified Person Contact Number			
Teacher / Identified Person Email			
School Attendance %			

GP Details	
Name of GP	
GP Address	
GP Contact Details	
Is the GP aware of the referral	YES NO

Reason for the Referral (multiple choices are allowed)							
Abuse		Anger		Anxiety		Bereavement	
Depression/ Low Mood		Domestic Abuse		Eating Disorders		Family	
Low self-esteem		OCD		Self-harm		Sleep Difficulty	
Suicidal		Trauma/PTSD		Violent Behaviour			
Other (please state)							

Detailed Reason for the Referral
Please provide a full explanation for the referral to Service Six *(where sufficient detail is not provided to warrant a referral this form may be returned to the referring agency or individual. The box will allow you to write as much as needed)*

Is the client involved in a CAF/EHA, FNM or any other such process?	YES NO
If yes please provide details	
Does the client/family have or is waiting for a designated social worker?	YES NO
If yes please provide details	

Please provide details of any other involved agencies and the key contact personnel assigned. Other agencies can include Doctors, Police, Women's Aid, CAMHS or other

Other Relevant Details (specifically health and Disability issues)

Please save this form and email it to: referrals@servicesix.co.uk

In the interest of security; please ensure that you have the correct spelling of the above email address prior to sending