**Key Worker Project Referral Form**

\*Please provide as much information as possible. Reports can be attached to avoid duplication if necessary.

Keyworker support 1:1

**Reason for referral: Key worker support**

Learning opportunities PBS Workshops

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| **Referrer Details** | **Date:**  | **Time:**  |
| **Name:**  | **Job Role:** |  |
| **Organisation/Team** |  |  |
| **Address:** |  | **Contact Number:** |
| **Email Address:** |  |  |
| **Is the family aware of the referral?** **Do they consent to the referral?** | **Yes ****Yes □**  |  |
| **Child/Young Person** |
| **\*Forename(s):**  | **\*Surname:**  |
| **\*Date of birth:**  | **\*Gender: F** |
| **\*Address:** **Postcode:** | **\*Current address**  |
| **\*GP Surgery & Telephone Number: Dr**  | **\*Preferred spoken Language:**  |
| **\*NHS Number: Not known** | **\*School/Nursery:**  |
| **\*Does the Child/Young Person have a diagnosis of autism?****Yes** **\*Additional Comments:** | **\*Does the Child/Young Person have a learning disability?** **\*Additional Comments** |
| **Parent/Carer/Emergency Contact Information** |
| **Contact 1** | **Contact 2** |
| **\*Name**  | **Name\***  |
| **Address (if different from above):** | **Address (if different from above):****Same as above.**  |
| **Postcode:** | **Postcode:** |
| **\*Contact Number:**  | **\*Contact Number:**  |
| **\*Email address:**  | **\*Email address:**  |
| **\*Relationship to Child/Young person:** | **\*Relationship to Child/Young person:**  |
| **Parental Responsibility: Yes** | **Parental Responsibility: Yes**  |

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| **Siblings Details**(Please continue on separate sheet if necessary) |
| **Name:** |  |  |  |
| **Age/DOB:** |  |  |  |
| **School/Nursery attended:** |  |  |  |
| **Significant information:** |  |  |  |

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| **Additional Information**Please provide details below including name and contact details if any professionals involved with family, where appropriate.  |
| Care Status/Looked After Child/ Child Protection/ CIN |  |
| Early Help Support |  |
| Residential School Placement |  |
| EHCP/ Provision support |  |
| Inpatient |  |
| DSR Status |  |
| **Overall Aims/ Outcomes: What does the referrer hope to achieve from this referral? What does the family hope to achieve from this referral? Have any areas of support been identified?**  |  |

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| **Parent/Carer Consent for Information Sharing**It may be necessary for the Key Worker Service to share information with relevant agencies involved in the support of your child or family.The purpose of information sharing is to gain a detailed picture of your child, including their strengths and areas of need. In order to meet these needs, we may have to include several services in this process, including new services that you may not have previously accessed.  We need your consent to share information with a variety of agencies deemed to be in the best interests of your child and/or family. This may include Health, Education, Social Care and Voluntary and Community Sector (VCS). Please note: This list is not exhaustive**Child’s name:** **Child’s D.O.B:** * I understand that by registering with the Key Worker Project I am consenting to my details being held on the database of The Daisy Chain Project.

 Demographic information will be anonymised for reporting purposes**.*** I understand that my information will be processed in accordance with the current General Data Protection Regulations (GDPR)
* I consent to information sharing between services and local authorities, as deemed necessary, in order to support my child and family.
* I understand that there are no set timescales for information sharing and this is dependent upon each individuals’ circumstances.
* **If we deem your child to be at risk of harm we may make a referral to another agency without consent, in the best interests of your child’s welfare and safety**
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| **Parent/Carer Name:** **Date:** **Signed:**  |

Please return completed form to:  keyworking@daisychainproject.co.uk

For office use:

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| Date referral received: |  |
| Keyworker allocated:  | **Yes □** **No □** |
| Referral Accepted |
| Name of KW allocated |  |
| Date of initial contact with Referrer |  |
| Date of initial contact with Parent/carer |  |
| Referral Declined |
| Reason(s) Please tick | Outside of age remit | Needs fully met by other agencies/services | No LD/ASC/concerns present |
| Outside of geographical reach | Refusal to engage | Other |
| If other please specify:  |
| Referrer informed of decision (date and brief notes of any discussions): |