**A close up of a logo

Description automatically generatedBreathing Space Therapeutic Services CIC**

**Secondary Alternative Provision Referral Form.**

Referral to:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Alternative Part-time Provision | 1:1 Therapy | Group Therapy | Animal Assisted Therapy | Emotional Health Workshop | Nurture through Nature | Targeted Support |
| Please tick as appropriate |  |  |  |  |  |  |  |

Referrer Details:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referral made by: | **Education Authority** | **Children’s Service** | **Health Service** | **Voluntary Sector** | **Self-Referral** | **Other** |
| Please tick as appropriate |  |  |  |  |  |  |
| Contact Name |  | | | | | |
| Relationship to YP |  | | | | | |
| Contact Address: |  | | | | | |
| Contact Number |  | | | | | |
| Contact Email |  | | | | | |
| Contact email for Invoice Purposes |  | | | | | |

Young Person’s Details:

|  |  |
| --- | --- |
| Young Person’s Name |  |
| DOB |  |
| Contact Address: |  |
| Contact Phone Number/Email |  |

Is the YP’s parent/guardian aware of this referral? Yes/No

Parent/Guardians Details (if different from referrer details):

|  |  |
| --- | --- |
| Contact Name |  |
| Relationship to YP |  |
| Contact Address: |  |
| Contact Telephone Number/Email |  |

|  |  |
| --- | --- |
| GP Name |  |
| GP Practice |  |
| Address: |  |
| Contact Number |  |

GP Details:

Does the YP have an EHCP? Yes/No

If this answer is yes, please include a copy of the EHCP when you submit this form

Does the young person have SEND? Yes/No

Is the YP in the care of the local authority? Yes/No

Is the YP currently on any medication: Yes/No

Please state medication below:

Is the young person aware of this referral? Yes/No

How does the young person feel about the referral?

**Reason for referral:** Please give an outline of your reasons for making this referral. Include any concerns you have, previous therapeutic interventions the YP has engaged in, barriers preventing YP from fully engaging in education (if applicable) and current need.

**Risk Awareness:**

Has the young person ever used self-harm as a coping mechanism or alluded to suicidal ideation? YES/NO

Details:

**Protective Factors:** please give details outlining any skills, coping strategies and additional support the young person currently has.

**What is the planned transition for the young person following their time with Breathing Space?**

|  |  |  |
| --- | --- | --- |
| Full-time return to their current school | Specialist setting | Currently undecided |
|  |  |  |

|  |  |
| --- | --- |
| **Name of Referrer** |  |
| **Position held** |  |
| **Signed** |  |
| **Date** |  |