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**Referral and Risk Assessment Form Monthly Activity Days (MAD’s)**

**Please feel free to use this form flexibly, in the way you feel is easiest. Please ensure all significant information is included and critical information is not accidentally omitted. Please try to be as succinct possible highlighting only relevant issues. Do not attach lengthy reports that are difficult to access and use in the context of an activity event. Please note we require one referral form per sibling. Please fill in all sections of this form.**

**Child/Young person’s details:**

|  |
| --- |
| Full name:  |
| Preferred name/nickname: |
| Date of birth:  |
| Gender:  |

**Current carer’s details:**

|  |
| --- |
| Name: |
| Address:  |
| Telephone: |
| Email:  |

**Person to contact in case of emergency if not current carer:**

|  |
| --- |
| Name:  |
| Address:  |
| Telephone number: |
| Email:  |
| Confirmation that someone can collect children in emergency and who this will be  |

**Who holds parental responsibility for this child?**

|  |
| --- |
| Name:  |
| Address: |
| Contact Number:  |
| Do they agree to their YP attending this event? |
| Consent to medical treatment?*\*Please ensure medical consent section at end of referral is signed* |

**Child/Young person’s legal status:**

|  |
| --- |
| Type of Order (if applicable): Date of Order:  |
| To which Local Authority: |

**Other information:**

|  |
| --- |
| Does this child/young person experience any speech or communication difficulties?  |
| Does this child/young person have any specific health needs or allergies? Are there any concerns such as bedwetting that need to be managed?Name and contact details of GP:  Address:  Phone: Name and contact details of dentist: *Please feel free to attach any further information you believe is necessary to ensure the health and safety needs of this young person are fully met* |
| Does this child/young person have any specific cultural or religious needs? What is the child’s Ethnicity?  |
| What are the child / young person’s likes & interests? |
| Name & contact details of referring Social Worker: |
| Line manager details: |

**Quality of Siblings relationship:**

|  |
| --- |
| What are the current contact arrangements for the siblings: |
| **Ongoing feed-back:** You are welcome to visit us or call to discuss siblings at any time.What kind of feedback might be helpful for you: |

**Photography**

Young people in the care system have often experienced disruption and loss in terms of photographic records of positive memories. Photography is an intrinsic aspect of this particular model. Each young person will have the opportunity to create a photograph album of their sibling holiday with family & friends. By signing below, you are consenting to the above activity taking place. We will seek extra permission before using any identifying photos for external promotion.

**Declaration: I confirm that the above information given in this referral/risk assessment is to the best of my knowledge a true and accurate account.**

Name of person making and completing this referral/assessment form:

Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*After the activity we will seek your feedback & comments (including those of the young people). These are highly valuable to us in order to help us evaluate and improve our work, and we hope that after the residential you will allocate time to reflect & discuss this with the young people to share their experiences.*

**Medical Consent DECLARATION:**

**Important:** Does the young person suffer from any medical conditions, or allergies that you think we should know about? If so please state these below or send a covering document with further details.

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Does the young person **take any medication? Yes No**

*If yes, please fill in the table below:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of medication** | **Form:** (i.e. tablets/ liquid/ injection) | **Dose** | **Dose per day** | **Other information** (i.e. taken with food) |
|   |   |   |   |   |
|   |   |   |   |   |

**Risk Assessment**

The MADs will consist of sibling groups of young people who are likely to be unfamiliar with one another. The safety and welfare of young people is Siblings Togethers’ paramount consideration.

It is essential that the person submitting this referral fully completes this section of the form. Accurate and detailed completion of this section is crucial to ensuring the safe management of the group dynamic. It will also ensure that we are able to fully consider individual needs. Missing or incomplete information in this section may cause delay or non-acceptance of the referral.

*\*****PLEASE NOTE*** *when referring a young person, please be clear regarding the young person’s behaviour. The young person will be MADs with other vulnerable young people and if their behaviour causes distress to others and we have not been forewarned of this, under certain circumstances, we will be forced to decide for them to leave for the well-being and safety of the group.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Risk area** | **Level of risk** **(High/Med/****Low)** | **Frequency of behaviour****(date/s of last concern/s)** | **Detailed description (What, where, how, who, why)** | **Current management plan. What is required to reduce this risk? Are there any triggers we need to be aware of? Please attach any existing behavioural/risk management documents if available.** |
| Aggression or violence towards others – including physical or verbal aggression |  |  |  |  |
| Substance abuse (type/s including smoking tobacco) |  |  |  | *\*Please note that young people are not permitted to carry lighters cigarettes or matches.*  |
| Victim or perpetrator of sexual abuse. |  |  |  |  |
| Suicidal thoughts or behaviour / Self-harm |  |  |  |  |
| Mental health/emotional concerns i.e. depression, bulimia, anorexia, etc. |  |  |  |  |
| Use of or the carrying of a weapon. |  |  |  |  |
| Other criminal behaviour (theft, shoplifting etc.) |  |  |  |  |
| Climbing or placing self in vulnerable situation i.e. running away. |  |  |  |  |
| Inappropriate contact with others (physical or communication i.e. phone/internet) |  |  |  |  |
| Any other significant risks you have identified that are not mentioned above? |  |  |  |  |

**Declaration: I confirm that the above information given in this referral/risk assessment is to the best of my knowledge a true and accurate account.**

Name of person making and completing this referral form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: Your feedback & Comments including those of the young people after sessions will be greatly valued and will provide guidance to our programme, benefiting of the young people it was created for. We hope that after the MADs you will allocate time to reflect & discuss this with your Young people to share their experiences.*

**Medical Consent DECLARATION:**

Important; does the young person suffer from any medical conditions, or allergies that you think we should know about? If so please state these below or send a covering document with further details.

**This must be signed by the person with ‘legal responsibility’ for the child/young person**

I agree to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ receiving emergency medical and dental treatment, including anaesthetics etc.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Young Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please return the form by email or post to:*

**Siblings Together Charity, 4 Market Place, Southwark Park Road, London SE16 3UQ.**

**or**

 **Email** **admin@siblingstogether.co.uk**

**Tel: 07501006711 - 07899892745**

 **2023-24**