

YOUNG PERSON’S REFERRAL REQUEST

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| --- | --- | --- | --- | --- |
| DAPL OFFICE USE ONLY DAPL | *Client ID No* |  | Date |  |

All completed Referrals to be returned to [ypreferral@dapl.net](mailto:ypreferral@dapl.net)

**Is this an appropriate referral for DAPL?**

Please answer the referral screening questions below to ensure the young person fits our criteria and to show that all other options have been considered.

**PLEASE RETURN COMPLETED FORM TO enquiries@dapl.net**

Please remember this referral is for counselling. It is not an emergency or crisis service. If the young person is expressing a wish to die and says that they have a plan of what to do, **you must** ensure that they are seen urgently by CAMHS or attend the local Emergency Department

<https://girfec.fife.scot/girfec/wp-content/uploads/sites/61/2018/08/Self-Harm-Guidance-Sept-2017.pdf>

**Option 1 Affected by own or another’s substance use** *(Anyone can refer via this route)*

**Criteria;**

* **Is the young person identified as using alcohol and or drugs?** Yes  No
* **Is the young person affected by another’s alcohol and or drug use?**  Yes  No

**Option 2 OMM Emotional Wellbeing** (*To be completed by Education Staff Only)*

**Criteria;**

* Is the young person presenting as emotionally distressed at the **additional**

to **intensive** stage outline within Our Minds Matter framework? Yes  No

**Option 3 Only for Schools who have comissioned DAPL through the Pupil Equity Fund (PEF)**

**Criteria;**

* Does the young person meet the criteria agreed by your school? Yes  No

**CHECK- Has the young person received all the possible support from in school resources?**

Anxiety Management  Seasons for Growth  Accessed Online Support

Anger Management  Nurture Group  7 Habits

School does not have additional support options

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| --- | --- | --- |
| **Prior to submitting a referral for counselling has there been a discussion of the young person’s needs with any of our partners and did they suggest a referral?** | | |
| **AGENCY** |  | **NAME OF WORKER** |
| CAMHS/Primary Mental Health Worker | YES |  |
| Education Psychologist | YES |  |
| School Nurse | YES |  |
| GP | YES |  |
| Other: | YES |  |

**We will not be able to accept a referral if the young person is already engaged with a counsellor or is accessing ongoing psychological support from another agency.**

**YOUNG PERSON’S DETAILS**

***Please complete all fields to ensure we have the information we need to undertake the work***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** | |  | | | | | |
| **DOB** | |  | | | | | |
| **YEAR IN SCHOOL (E.G S2 etc)** | |  | | | | | |
| **ADDRESS** | |  | | | | | |
| **TOWN** | |  | | | | | |
| **POSTCODE** | |  | | | | | |
| **TELEPHONE** | |  | | | | | |
| **Young Person’s MOBILE** | |  | | | **OK TO TEXT?** | YES | NO |
| **Young Person’s EMAIL** | |  | | | | | |
| **Has the Young Person Given Consent for this referral to be made? Yes  No** | | | | | | | |
| **Are the parents/carers aware of this referral? Yes  No** | | | | | | | |
| **Name of next of kin /emergency contact** | | |  | | | | |
| **Email** |  | | **Telephone** |  | | | |
| **ALL APPOINTMENTS WILL BE OFFERED IN SCHOOL OR VIA ONLINE OR TELEPHONE. APPOINTMENTS MAY OCCASSIONALLY BE OFFERED OUTWITH SCHOOL IF APPROPRIATE AND RESOURCES ALLOW.** | | | | | | | |
| **Please explain the reason for needing appointments outside school.** | | | | | | | |

**REFERRER’S DETAILS**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME OF SCHOOL** | | | |  | | | | | | |
| **NAME OF REFERRER** | | | |  | | | | | | |
| **EMAIL** |  | | | | | **TEL** |  | | | |
| **NAME OF GUIDANCE TEACHER** | | | |  | | | | | | |
| **EMAIL** |  | | | | | **TEL** |  | | | |
| **NAME OF GP IF KNOWN** | | |  | | | | | | | |
| **NAME OF SURGERY** | | |  | | | | | | | |
| **NAME OF SOCIAL WORKER IF KNOWN** | | | | | |  | | | | |
| **EMAIL** |  | | | | | **TEL** |  | | | |
| Is the young person being offered additional support via: | | | | | | | | | | |
| PSS | | MST | | | AFT | | LAC | | AT RISK REG | |
| **Is this young person actively working with CAMHS or another counsellor** | | | | | | | | YES | | NO |
| **Is this young person actively working with the school’s OMM PSO** | | | | | | | | YES | | NO |

**PRESENTATION SUMMARY**

The initial presenting issue may hide the wider details. Please ask directly if any of the co-occurring issues are noted as a factor when placing a referral.

|  |  |  |
| --- | --- | --- |
| PRESENTNG ISSUE |  | TYPE, AMOUNT, RELATIONSHIP OR ISSUE |
| **DRUGS** | Yes |  |
| **ALCOHOL** | Yes |  |
| **AFFECTED BY ANOTHER’S USE** | Yes |  |
| **BULLYING** | Yes |  |
| **STRESS** | Yes |  |
| **ANXIETY** | Yes |  |
| **LOW MOOD/DEPRESSION** | Yes |  |
| **TRAUMA** | Yes |  |
| **LOSS** | Yes |  |
| **COVID/LOCKDOWN** | Yes |  |
|  |  | **What action have you taken to ensure safety** |
| **SELF HARM** | Yes |  |
| **SUICIDE** | Yes |  |

**IDENTIFIED AREAS FOR CHANGE**

|  |
| --- |
| **Please note key areas of behaviour and or presentation identified for change.**  *(Please do not copy and paste* CAMHS, PMHT, SNS or other NHSnotes here, provide your own observations) |
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**ADDITIONAL NOTES:**

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| **Please note communication needs, access issues or risk factors etc.** |
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| *DAPL OFFICE USE ONLY* **DAPL COORDINATORS INITIAL GRADING** | | |
| GREEN |  |  |
| AMBER |  |  |
| RED |  |  |
| CHECKED & GRADED BY- MD  JK | | |