

**REFERRAL FORM**

If you wish to make a referral, please contact **Teenlink** on **028 71 416 800.**

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| --- |
| **Referral Date:** |

**Referrer’s Details**

|  |  |  |
| --- | --- | --- |
| Name | | Organisation |
| Address (incl postcode) | | |
| Telephone: | Email: | |

|  |  |  |
| --- | --- | --- |
| Has the young person and parent/carer consented to this referral? | Yes | No |
| Consent Form Attached? | Yes | No |

**Young Person’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth:** | | **Age:** |
| **Address (incl postcode)** | | | |
| **Telephone:** | | **Male** | **Female** |
| **Has the young person any disabilities?** | | **Yes ☐** | **No ☐** |
| *If ‘Yes’ please give details*: | | | |
| **Does the young person have any medical conditions we need to be aware of?** | | **Yes** | **No ☐** |
| *If ‘Yes’ please give details* | | | |
|  | |  |  |

**Emergency Contact Details**

|  |  |
| --- | --- |
| Name of Emergency Contact: | Tel No: |
| Address (incl postcode) | |
| Relationship to Young Person: | |

**Parent/Carer’s Details** (if different from above)

|  |  |
| --- | --- |
| Name of Parent/Carer: | Tel No: |
| Address (incl postcode) | |

**Has the young person:**

Lived in an environment where there was domestic violence? Yes  No

Does the young person have any mental health issues and/or diagnosis? Yes  No

Has or is the young person involved with Foyle Women’s Aid? Yes  No

Has the young person any problems or issues in relation to drugs/alcohol/substances? Yes  No

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| --- |
| If you have answered ‘**Yes’** to **any** of the above, please give all relevant information needed to safeguard the young person being referred: |

|  |
| --- |
| **Please give brief details about why you believe this programme may benefit this young person:**  (Where possible, please include areas/issues the young person and/or you would like the programme to address and the benefits you hope the young person might gain from being involved.) |

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| To ensure each young person gets the maximum benefit from the programme, please state any considerations that you are aware of that may need to be accommodated, e.g. social anxiety, shyness, difficulty with peer relationships in the past etc: |

Date referral received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oasis Ref: Date added:

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Action | Outcome | Worker’s Initials |
|  |  |  |  |
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**TEENLINK CONSENT FORM**

Your son/daughter has been referred to our Teenlink programme, which was specifically designed for young people 11-16 years who have experienced domestic and sexual abuse. This programme consists of group work and the offer of one-to-one support should the young person need it. There will also be a social element to the programme, such as a summer scheme and youth club.

The aim of the Teenlink programme is to address issues your child may be experiencing as a result of living in a home where there was domestic abuse. They will have the opportunity to talk about their experiences with experienced, qualified staff and in a safe environment.

If you would like your child to be considered for the programme, please complete the Consent Form below and return to the address provided.

If you require any further information, please do not hesitate to contact the team on:

Tel: 028 71 416 800 or by email [info@foylewomensaid.org](mailto:info@foylewomensaid.org)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to my son/daughter

Parent/Carer’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Young Person’s Name

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

Please Return to:

Foyle Women’s Aid

Children & Young People’s Service

24 Pump Street

DERRY/LONDONDERRY

BT48 6JG