Please contact the team on 01323 324010/[esccivservice@asphaleia.co.uk](mailto:esccivservice@asphaleia.co.uk) for advice or support in completing this referral. If you do not have confirmation or receipt of your referral within 24 hours please email or call on the details above.

Referrals for independent visitors require individuals to consent **before** their personal data can be shared. To ensure that this consent is sufficient to comply with data protection legislation, the following will need to be explained to the child or young person.

* Personal information about them, including data about their health and race/ethnicity, may be shared as part of this referral.
* Some of this data might be provided directly by them during the referral. Some information already held about them by ESCC will also be shared.
* This data will only be shared as necessary with [insert name of provider] to enable them to provide the young person with the most appropriate advocate or independent visitor.

They can withdraw their consent if they decide they no longer want to receive this service in the future. They should contact their social or key worker if they want to do this.

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| --- | --- |
| Please confirm that the child / young person understands the above and has given their consent for this referral: | Yes ☐ |
| If the child or young person is not able to consent (due to their age or medical conditions) then please confirm that consent has been gained from the individual via parental consent. | Yes ☐ |

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| Service user details | |
| Child/young person’s name: | |
| Address:  Any pets at the address? Please give details: | Ethnicity: |
| D.O.B: |
| Gender: |
| Contact Number: | Preferred contact method: |
| Child / young person’s legal status: | Child in Need ☐ |
|  | Child in Care ☐ |
|  | Care Leaver ☐ |
|  | Not sure ☐ |
| Date child / young person became looked after: |  |
| Resident Local Authority? ☐ | If no – please state placing L.A. |
| Please check this box if the child / young person has a CP plan ☐ | |

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| --- | --- |
| Referrer details This young person has consented to this referral: ☐ | |
| Date of Referral: | Referred by: |
| Organisation & Job Title: | Tel: |
| Email: | Mobile: |
| Address: | |

|  |  |  |
| --- | --- | --- |
| Parent / Primary Carer’s details | | |
| Parent / Primary Carer’s Name: | | |
| Address: | Telephone number: |  |
| Email: |  |
| Is the parent / carer aware of this referral? |  |  |

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| --- | --- |
| Child / Young Person’s Social Worker details, if different from above | |
| Name: | Email: |
| Landline: | Mobile: |
| Address: | |
| Other professionals / agencies involved: | |

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| --- | --- | --- |
| Child / Young person’s school / college details | | |
| Name of school / college: | | |
| Address: | Telephone number: |  |
| Email: |  |
| Teacher / tutor / safeguarding lead as appropriate: | | |

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| Brief reason for Independent Visitor referral: | |
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| Please attach care plan if IV referral was agreed at a LAC review. | |
| Is the referral for an Independent Visitor part of Leaving Care Pathway Planning? | Y/N? |

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| --- | --- |
| Targeted area/s of support for Independent Visitor referrals (please tick at least one) | |
| Healthy lifestyle |  |
| Emotional Wellbeing |  |
| Positive people |  |
| Confidence and self esteem |  |
| Future plans |  |
| Engagement with ETE / NEET? |  |
| Keeping safe |  |
| Safety from substances |  |
| Additional Information, including details of any support networks / agencies involved with the young person | |
|  | |

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| **SAFEGUARDING/ADDITIONAL NEEDS** | | | | | | | | | | | | | | |
| Risk/Danger to (YES or NO must be entered) | | | | | | | | | | | | | | |
| Staff |  | Self |  | Public |  | Children |  | Adults | |  | | Other |  | |
| Additional risk/concerns | | | | | | | | | | | | | | |
| Gang Involvement | | |  | Child sexual exploitation | | |  | Radicalisation |  | | | | | |
| If yes to any of the above please give details: | | | | | | | | | | | | | | |
| Any vulnerability? (mental health, disability, learning disabilities, substance use etc) | | | | | | | | | | | YES | | | NO |
| If yes please give details: | | | | | | | | | | | | | | |
| Preferred language / any communication needs: | | | | | | | | | | | YES | | | NO |
| If yes please give details: | | | | | | | | | | | | | | |
| General background and/or specific needs | | | | | | | | | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- |
| Targeted area/s of support for Independent Visitor referrals (please tick at least one) | | | | | | |
| Healthy lifestyle | | | | |  | |
| Additional Information, including details of any support networks / agencies involved with the young person | | | | | | |
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| Please check this box if you (or another trusted adult) wish to be present for the Initial Meeting | | ☐ |
| Has this been discussed and agreed with the child / young person? | Yes | No |

|  |  |
| --- | --- |
| asphaleia use only | |
| Date referral received |  |
| Receipt sent to referrer |  |
| Initial contact date |  |
| Date IM carried out |  |