



Referral Form Residential Services

Please complete this form giving as much information as possible and return by email to referrals@togethertrust.org.uk

For Office Use Only
Reference Number:

Referral details

Unit Name (if you have a preference)	
Date Placement required	
Type of Placement required	Emergency placement Yes <input type="checkbox"/> No <input type="checkbox"/> Fast Track Yes <input type="checkbox"/> No <input type="checkbox"/> Planned placement Yes <input type="checkbox"/> No <input type="checkbox"/> Disabled service Yes <input type="checkbox"/> No <input type="checkbox"/> Short term break Yes <input type="checkbox"/> No <input type="checkbox"/> Shared Care Yes <input type="checkbox"/> No <input type="checkbox"/> If planned please give length of placement: Short term <input type="checkbox"/> Medium term <input type="checkbox"/> Long term <input type="checkbox"/>
Education Required	Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of Placement required	
Location of Placement required	
Date of Referral	
Person making Referral	
How did you hear of us?	
Telephone Number	
Email Address	
Social Worker Name	
Social Worker's Telephone Number	
Social Worker's Email Address	
Local Authority	
Address	

Personal details

Child/Young Person's Name	
Gender	
Date of Birth	
Place of Birth	
Ethnic Origin	
Religion	
First Language	
Name(s) of parent(s) or person(s) with parental responsibility	
Telephone number	
Address	
Child's present address and telephone number (if different from above)	
Name of present primary carer	
Reason placement required	
Legal Status	
Disability Register (If yes – please give details)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Background information

Date of care order or request for placement	
Grounds for care order or reasons for placement	
Assessment Details	
Date of Initial Assessment	
Date of Core Assessment	
Date of Specialist Assessment (if required)	

Record of placements whilst being looked after by the Local Authority				
Type of placement and name of carer	Address	Dates		Reason for Leaving
		From	To	
Reason for placement being sought, primary aim or objective				

Family details

Mother's Name:	Father's Name:	
Date of Birth:	Date of Birth:	
Telephone No:	Telephone No:	
Address:	Address:	
Siblings		
Name	Date of Birth	Address
Other Significant Adults		
Name	Relationship	Address
Please give details of any restrictions on contact:		
Please give details of any cultural and religious needs		

Presenting behaviour of child/young person

The decision to place a child/young person depends on accurate information about their behaviour. Any placement will be at risk of immediate closure should this information subsequently prove inaccurate.		
Is there any history of physical assault on peers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of physical assault on adults?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the young person likely to bully others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the young person likely to be victimised?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of verbal aggression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of criminal damage in residential units?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was the above either serious or frequent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any history of non-accidental injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any history of sexual/emotional abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the young person subject to a Children Protection Plan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the young person sexually active?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any reason to believe the young person is sexually coercive or may abuse other young people?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the young person demonstrate sexualised behaviour?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of self-harm?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the young person outspokenly racist/sexist in expression?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of Arson?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any history of fire-setting etc?*	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the young person understand consequence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the young person have any sense of personal responsibility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can the young person relate well to adults?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can the young person relate well to peers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

***The Together Trust cannot admit a young person who has a fire-setting or arson risk as an emergency referral.**

Any Further Information:

A large, empty rectangular box with a thin black border, intended for providing additional information.

Key agencies

Key Agencies (please complete contact details if currently working with child/young person)	
Agency	Contact Name and Telephone Number
GP	
Dentist	
School Nurse	
Community Paediatrician	
Health Visitor	
Nursery	
School	
Education Welfare Officer	
Police	
Youth Offending Team	
Other (please specify)	
Other (please specify)	
Other (please specify)	

Education

Name and address of current / previous school or educational establishment		
Telephone Number		
Name of Head Teacher		
Name of Class Teacher		
Has a Personal Education Plan been completed?		
Date and arrangement for Review		
Has the child been statemented as being in need of special education? Is there extra support in place in mainstream school and for what reason: please specify		
Academic or vocational qualifications held by the young person		
Date	Subject Area	Qualification

Education (continued)

Other achievements, interests or hobbies			
Schools attended (from age 5)			
Date from	Date to	Name and address	Reason for leaving
Details of educational involvement from other agencies e.g. child guidance			
Has a psychiatric/psychological assessment been made in relation to child/young person?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Originator			
Date of Assessment			
Is process in progress or being considered?			Yes <input type="checkbox"/> No <input type="checkbox"/>

Health

Name, address and telephone number of Doctor	
Name, address and telephone number of Dentist	
Name, address and telephone number of Consultant/Community Paediatrician	
Name, address and telephone number(s) of other agencies involved	
NHS Number	
Please give details of any allergies	
Please give details of any pending health appointments	
Please give details of any special health care requirements	
Please give details of any special dietary needs	

Disability

Disability	
Medical Conditions	
Additional Disabilities (e.g. Hearing/Visual Impairment)	
Allergies – please specify Does this affect behaviour? Is it worse at certain times of year?	
Medication	
Continence Care Support	
Therapeutic Support (e.g. Physiotherapist, Occupational Therapist, Speech & Language)	
Day Service Provision (if any)	

Disability (continued)

Skills – What is the young person's current level of ability in the following areas and support required	
Communication	
Comprehension	
Self Care	
Mobility	
Independence Skills	
Socialising	
Behaviours	
Any other relevant information	

Specific information

Court Orders currently affecting the child			
Date	Reason	Type of Order	Duration

Please give details of any criminal behaviour or pending court appearances			
Date	Offence	Heard or to be heard at	Disposal/sentence

Please complete this form and return by email to referrals@togethertrust.org.uk

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