**Young Persons Referral Form**

**Criteria for referral:**

The young person must be aged between 13 & 19, be a resident of, and/or attend a school in the Ashfield, Mansfield, Newark & Sherwood area. The age criteria can extend to age 24 if the young person has a registered learning disability.

***Please note, we cannot accept a referral if the young person is below the age of 13.***

The young person must have consented to the referral.

The SEXions service offers one 1:1 visit in a school, college or alternative educational environment.

***Please note, we cannot make home visits at this time.***

We provide support to young people with the following concerns:

* Contraception & Sexual Health
* Healthy Relationships
* Child Exploitation & Sexting

When completing the referral form, please provide as much information as possible, including any past work undertaken by other services such as Social Care, Police etc.

All referrals are reviewed once a week, and if deemed suitable, a SEXions worker will be allocated, and 1:1 support will be arranged.

SEXions staff will make two attempts to visit the young person referred. Should the young person fail to attend, they will be discharged from the service and the referral form will be returned to the referrer.

Please email the completed referral form to: **sfh-tr.sexions@nhs.net**

*Please note that boxes will expand as information is typed*

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| **Referred by:** |  | **Date:** |  |
| **Role:** |  | **Contact No:** |  |
| **For ISHS Staff only: Lilie number:** | |  | |

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| **Young person has given consent:** | | **Yes / No** \*please delete |
| **Name of Young Person:** |  | |
| **Date of birth:** |  | |
| **Gender & pronouns:** |  | |
| **Ethnicity:** |  | |
| **Address:** |  | |
| **Contact Number:** |  | |
| **Preferred time and place for contact:** |  | |
| **School/Training provider:** |  | |
| **Learning difficulties / Special Educational needs:** |  | |
| **GP details:** |  | |

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| **Other Agencies involved:** | | | |
| **Agency:** |  | | |
| **Name:** |  | **Contact No:** |  |
|  | | | |
| **Agency:** |  | | |
| **Name:** |  | **Contact No:** |  |

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| **Nature of referral / Background information:** |  |

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| **Referral taken by:**  (name / job title) |  |
| **Date:** |  |