**The Bambu Project works with CYP living with domestic abuse**

Please send the referral to: **Bambu@risemutual.org**. Once allocated to a Practitioner from either RISE Mutual CIC or Richmond Fellowship, an Initial Assessment will be arranged.

**Richmond Fellowship will provide for the 11-15 age group: A therapeutic service comprising of 1-2-1 psychological therapy/counselling/creative arts and play therapy or resilience workshop for children who have been affected by domestic abuse.**

**RISE Mutual CIC will provide for the 16-24 age group: A therapeutic service comprising of 1-2-1 trauma-informed psychological therapy/counselling and resilience sessions for young people who have been affected by domestic abuse.**

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| **DATE OF REFERRAL:** | |  |
| **Referral Criteria Check List:** Please confirm that the following referral criteria are being met as appropriate. (please highlight) | | |
| **CYP are between 11-24 years old** | | **Y/N** |
| **CYP’s lives have been impacted by domestic abuse** | | **Y/N** |
| **CYP live in a safe/ secure accommodation** | | **Y/N** |
| **The perpetrator is not living in the family or if there is contact, this is supervised or safe contact?**  **If the answer is Yes, Children’s Therapy can apply**  **(if the answer is no, it may not be safe)** | | **Y/N** |
| **Chronology and all reports attached** | | **Y/N** |
| **CYP is Resident of/student in (select the appropriate borough)** | | **Islington**  **Haringey**  **Enfield**  **Tower Hamlets**  **Croydon**  **Lambeth**  **Hammersmith and Fulham**  **Hounslow** |
| **REFERRER DETAILS** | | |
| **NAME:** |  | |
| **Title and ORGANISATION:** |  | |
| **EMAIL:** |  | |
| **TELEPHONE NUMBER:** |  | |
| **DESIGNATED ROLE:** |  | |
| **Name of Allocated Social Worker (if not the same as referrer):** | | |
| **NAME:** |  | |
| **Title and ORGANISATION:** |  | |
| **EMAIL:** |  | |
| **TELEPHONE NUMBER:** |  | |

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| **YOUNG PERSON DETAILS (please complete fully)** | | | |
| **YOUNG PERSON NAME:** |  | | |
| **DOB:** |  | | |
| **GENDER:** |  | | |
| **ADDRESS:** |  | | |
| **TELEPHONE NO (if applicable):** |  | | |
| **RACE / ETHNICITY:** |  | | |
| **RELIGION:** |  | | |
| **IS AN INTERPRETER REQUIRED** | YES / NO – Language: | | |
| **Details of any sibling(s) not being referred:** | |  | |
| **NON-ABUSIVE PARENT / CARER DETAILS (please complete fully)** | | | |
| **PARENT(S) / CARER(S) NAME:** |  | | |
| **DOB:** |  | | |
| **RELATIONSHIP TO THE YOUNG PERSON:** |  | | |
| **TELEPHONE NUMBER:** |  | | |
| **LIVES AT SAME ADDRESS AS CYP?** |  | | |
| **EMAIL ADDRESS:** |  | | |
| **RACE / ETHNICITY:** |  | |  |
| **RELIGION:** |  | | |
| **IS AN INTERPRETER REQUIRED:** | YES / NO : | | Language: |

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| **Perpetrator name, address (if known) and D.O.B:** | Name:  Address:  D.O.B: |

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| **PLEASE ANSWER THE FOLLOWING QUESTIONS** | | | | |
| **Please provide us with as much detail as you can :-** | **Yes** | **No** | **Not Known** | |
| Does the young person need help with reading/writing?  If yes, give details below: - |  |  |  |
|  | | | |
| Has the young person been excluded from mainstream education?  If yes, give details below: - |  |  |  |
|  | | | |
| Is there threat of exclusion from mainstream education?  If yes, give details below: - |  |  |  |
|  | | | |
| Is the young person at risk of or involved in criminal activity?  If yes, give details below: - |  |  |  |
|  | | | |
| Does the young person have any special educational needs?  If yes, give details below: - |  |  |  |
|  | | | |
| Is the young person at risk of, or engaging in any gang activity?  If yes, give details below: - |  |  |  |
|  | | | |
| Are there any mental or physical health issues we should know about?  If yes, give details below: - |  |  |  |
|  | | | |
| Does the young person use any drugs or alcohol?  If yes, give details below: - |  |  |  |
|  | | | |
| Young person’s attitude to referral? | | | |
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| **Safeguarding INFORMATION (Please give details):-** | | |
| **Do any of the children have an** **Educational Health and Care Plan** (please highlight)? | | **Y/ N / Under Assessment** |
| Child(ren’s) name(s): | | Date of plan: |
| **Have social care ever been involved with the family?**  (Please highlight) | | **Y/ N Present / Previously** |
| If yes, please give details: | | |
| **Are any of the children subject to a CP or CIN plan?** | | **Y/ N** |
| Child(ren’s) name(s): | Date of plan:  Category:  Review date: | |

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| **Previous Therapy or other Support services** | **Yes** | **No** | **Not Known** | |
| Has the child/young person attended therapy or engaged with domestic abuse services before? |  |  |  |

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| **OTHER Professional involved** (Include Education Welfare, Family support worker, CAFCASS, YOT, CAMHS, Learning mentor, National Probation Service. |
| Please provide Name, telephone number and email address: |
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| **Information sharing** | **Yes** | **No** | **Not Sure** | |
| Are there any specific instructions around the **safety of information being shared** (e.g., address is not to be released, caregiver cannot be written to at home.) |  |  |  |
| If yes, please give details: | | | |

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| **PLEASE ANSWER THE FOLLOWING QUESTIONS** | | | |
| **Please provide us with as much detail as you can :-** | **Yes** | **No** | **Not Known** |
| Does the parent/carer have any mental or physical health issues we should know about? If yes, give details below:- |  |  |  |
|  | | | |
| Does the parent/carer use any drugs or alcohol?  If yes, give details below:- |  |  |  |
|  | | | |
| Is there current domestic violence/abuse?  If yes, give details below:- |  |  |  |
|  | | | |
| Parent/carer’s attitude to referral? | | | |
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| Please give details (name, age, relationships) of any other persons within the household | | | |
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| **REASON FOR REFERRAL to the Bambu Project - please state why you are referring the young person/family to the programme and provide any other information that may be useful.** | | | | | |
|  | | | | | |
| **Concerns:**  Please identify up to four concerns and indicate the level of that concern in table below (please tick): | | | | | |
|  | **concerns** | **Not at all concerned** | **Somewhat concerned** | **Concerned** | **Very concerned** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |

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| **Hopes and Expectations**  Which 4 outcomes on the list would you most like the service to achieve (please tick)? | | | |
|  | Greater ability to manage their feelings better |  | Increased feeling of happiness |
|  | Greater ability to listen |  | Greater ability to feel better about themselves |
|  | Greater ability to communicate with others |  | Greater ability to manage their behaviour |
|  | Greater ability to concentrate on their work |  | Greater ability to deal with experiences of DV |
|  | Increased feeling of safety |  | Other (please state): |

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| --- |
| **Signature and confirmation:** |
| All clients (or parents / guardians) must be aware that a referral is being made to RISE/Richmond Fellowship and that we will contact them via the contact details provided on this form.  **Please highlight preferred method of contact for parent/carer:**  **Phone: Email: Text: Letter:**  **NAME and SIGNATURE OF REFERRER:**  **DATE:**  **Please tick to indicate the parent’s consent YES:  NO:** |
| **Please tick to indicate the young person’s consent YES:  NO** |