MARIE SHIELDS

Tel:02038931925
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49A Chilternview Road, Uxbridge.UB8 2PF

Referral Form

Social Worker Questions

Personal Details	
Name of child/ Young Person: (Full name including middle names)	
D.O.B:	
Current Address and postcode:	
National Insurance Number:	
Height:	
Weight (Approx.):	
Background and Needs	
Social Worker, Name and details:	
Reason for referral:	
Is the child/ young person currently in a care home:	
Reason for breakdown at current placement:	
Child/ young person's background:	
Information about the child/ young person's family:	
Contact arrangements with the family/ Visitation arrangements:	
Has a mental health capacity assessment ever been conducted: *(Please tick ✓as appropriate)*	☐ Yes ☐ No *(Please list and attach details of Assessment or Reports)*
Legality/ Which section of the Court Order:	
Do they have an Educational, Health Care Plan (EHCP)?	☐ YES ☐ No
Does the child/ young person have any Diagnosis? *(Please tick ✓as appropriate)*	

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Autism (ASD/ASC) ☐	Attention hyperactivity Disorder (ADHD) ☐	Opposition Defiance Disorder (ODD) ☐
Obsessive Compulsive Disorder (OCD) ☐	Social, emotional and mental health ☐	Speech, language and communication needs/difficulties ☐
Visual impairment ☐	Hearing impairment ☐	Moderate learning difficulty ☐
Severe learning difficulty ☐	Other, Please Specify ☐	

Current or previous behaviour's that the child/ young person has displayed?		
Hitting/punching somebody else ☐	Self-harm (including punching a wall in frustration) ☐	Damage to property ☐
Kicking ☐	Spitting ☐	Head- Butting ☐
Throwing small items (such as books, pens etc.) ☐	Throwing large items (such as chairs, tables etc.)☐	Carries a weapon (or has been known to) ☐
Used a weapon on another person before ☐	Arson, actual or attempt ☐	Discriminatory language ☐
Racist language ☐	Extremist views/ idealisation ☐	Absconding ☐
Alcohol misuse ☐	Drug misuse ☐	Smoking/ Vaping ☐
Other, Please Specify:		

Education	
Name of current school or college:	
Address:	
Educational status/history:	
Telephone Number:	
Email contacts:	

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Transport	
Transport details (If applicable):	
Medical/ Therapy Information	
Name of GP and Surgery:	
Surgery Address:	
Telephone Number:	
Email Address:	
Any past or present medical issues:	
Allergies:	
Medication currently being taken:	
Optician, address, last visit, outcome:	
Dentist, address, last visit, outcome:	
Therapy needs/ appointments:	
Do they have any sensory issues relating to; sound, taste, feel, light, smell?	

Independent Skills

Will the child/ young person be independent in the following:

Washing themselves: ☐ Yes ☐ No	Dressing themselves: ☐ Yes ☐ No	Washing their clothes: ☐ Yes ☐ No
Cleaning their room: ☐ Yes ☐ No	Managing money: ☐ Yes ☐ No	Cooking for themselves: ☐ Yes ☐ No
Access the internet safely:	Completing household chores:	Travelling independently:

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☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there anything else that is important that we should know before working with this child/ young person:		

Other Key information	
Do the/ will they have friends in the Local Community?	
Can they get public transport?	
Have they got any specific hobbies?	
Do they have a phone/ laptop or console that they will be bringing with them?	
How much belongings do they have/ will they bring?	
What are the weekly professional meeting expectations?	
Current staffing ratio?	
Any other relevant information we should know? (Team to input key lines of enquiry based from the original referral)	

Young Person Questions

Personal Details	
Name:	
What do you like about your current placement?	
Which and why do you like certain staff members?	
What are your hobbies and interests?	
What are your favourite colours?	
Are you able to be safe on a; train, bus, taxi, tram?	
What do you enjoy?	
What are you like with education?	

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What do you find difficult about education?	
What would motivate/incentivise you?	
What makes you feel calm?	
What are your behaviours?	
What are your triggers?	
What kind of foods do you not eat?	
Do you have any sensory issues relating to; sound, taste, feel, light, smell?	
What is your bedtime routine?	
What is your bath time routine?	

Current or previous behaviour's that you have displayed?		
Hitting/punching somebody else ☐	Self-harm (including punching a wall in frustration) ☐	Damage to property ☐
Kicking ☐	Spitting ☐	Head- Butting ☐
Throwing small items (such as books, pens etc.) ☐	Throwing large items (such as chairs, tables etc.)☐	Carries a weapon (or has been known to) ☐
Used a weapon on another person before ☐	Arson, actual or attempt ☐	Discriminatory language ☐
Racist language ☐	Extremist views/ idealisation ☐	Absconding ☐
Alcohol misuse ☐	Drug misuse ☐	Smoking/ Vaping ☐
Other, Please Specify:		

Independent Skills		
Are you independent in the following:		
Washing yourself: ☐ Yes ☐ No	Dressing yourself: ☐ Yes ☐ No	Washing your clothes: ☐ Yes ☐ No

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Cleaning your room: ☐ Yes ☐ No	Managing money: ☐ Yes ☐ No	Cooking for yourself: ☐ Yes ☐ No
Access the internet safely: ☐ Yes ☐ No	Completing household chores: ☐ Yes ☐ No	Travelling independently: ☐ Yes ☐ No
Is there anything else that is important that we should know before working with this child/ young person:		