CHOICES
Providing access to emotional support
for children, young people and their families in Haringey

Professionals Referral form

Details of Referrer (If you are a parent please complete the details for the Child/Young person)

Name of Professional:						
Your profession:	**GP**	**SENCo/Teacher**	**Social worker**	**Family support worker**	**Other**	

Work address:	
Contact number:	
Email:	

Have the parents agreed to this referral?
YES _____ NO _____

If no please state why _____

Has the young person agreed to this referral?
YES _____ NO _____

If no please state why _____

Details of Child/Young Person

Name of Child/ Young person:		**D.O.B:**	

Gender			
Female		Male	
Other		Prefer not to disclose	

Ethnicity			
White – English/Welsh/Scottish/ British(16)		Bangladeshi(7)	
White – Irish(17)		Indian(5)	
White – Any other white background(19)		Pakistani(6)	
African(1)		Chinese(10)	
Caribbean(2)		Any other Asian background(11)	

Any other black background(4)		Greek / Greek Cypriot(20)	
White – Asian(14)		Turkish / Turkish Cypriot(22)	
White and black African(13)		Kurdish(24)	
White and black Caribbean(12)		Any other background(25)	
Any other mixed heritage(15)			

What language would the child/young person prefer us to use?			
English(1)		Portuguese(9)	
Albanian(2)		Polish(10)	
Arabic(3)		Somali(11)	
African(1)		Spanish(12)	
Bengali(4)		Turkish(13)	
French Lingala(5)		Twi(14)	
Greek(6)		Youruba(15)	
Hindi(7)		Other(20)	
Kurdish(8)		Prefer not to disclose(21)	

Contact Number:	
Email Address:	
Home Address:	
Details of parent/carer: **Name:** **Contact no:** **Email:**	
Your school details: **Name:** **Address:** **Contact no:**	

Is the Child/young person known to or have been known to any other community organisations?					
CAMHS	Open Door	Social services	Early Help	Other	None

Where did you find out about CHOICES?			
Word of mouth		School	
Internet search		Community organisation	
GP		Advertising material	
Social media (Instagram, FB,Snapchat)		Other	
Newspaper			

Please choose ONE of the following that is concerning you			
Feeling low in mood		Eating problems	
Panic		Worries about weight	
Anger issues		Obsessions (OCD)	
Behaviour problems		Difficulties sitting still or concentrating	
Problems making or keeping friends		Traumatic event(s)	
Bullying		Family problems	
School issues		Anxiety	
Self-Harm		Other not listed	
Sleeping problems			

Please add ANOTHER if something else is concerning you			
Feeling low in mood		Eating problems	
Panic		Worries about weight	
Anger issues		Obsessions (OCD)	
Behaviour problems		Difficulties sitting still or concentrating	
Problems making or keeping friends		Traumatic event(s)	
Bullying		Family problems	
School issues		Anxiety	
Self-Harm		Other not listed	
Sleeping problems			

Please describe your worries for the child/young person in as much detail as possible…

(Please include how these worries interfere with home life, friendships, classroom learning, leisure activities)

How long have these difficulties been present?	
< month	
1-5 months	
6-12 months	
Over a year	

Does the child/young person have any long term illness, health problem or disability which affects their daily activities or the education or work they do?		
Yes	No	Prefer not to say

Does the child/young person make use of any of the following methods to help communicate?			
No		American sign language(4)	
Braille(1)		British sign language(5)	
Makaton(2)		Other support(6)	
Australian sign language(3)		Prefer not to disclose(7)	