

# Presenting Difficulties

## Identified Needs

### Likelihood of Reoccurrence

| Risk                              | Likelihood of Reoccurrence |                          |                          |                          |                          |                          |
|-----------------------------------|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                   | Low                        | Med                      | High                     | Low                      | Med                      | High                     |
| Aggression / Anger / Temper       | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self Injury                       | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Offending Behaviour               | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexualised Behaviour              | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Peer Group Difficulties           | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional Well Being              | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk Taking                       | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discriminatory Behaviour          | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug / Alcohol / Substance Misuse | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running Away                      | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Complaints / Allegations          | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child Protection Issues           | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Criminal Damage                   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Violence Towards Staff            | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



Is there any history of child sexual abuse, emotional abuse, physical abuse or neglect?

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Are they on the Child Protection "At Risk Register?"

Yes [ ] No [ ]

Are there any agencies currently involved with this young person?

Yes [ ] No [ ]

If yes, please give details of agency, worker and reason for involvement:

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Are there any arrangements for contact?

Yes [ ] No [ ]

If yes, please give details:

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Are there any persons whom contact is restricted or forbidden?

Yes [ ]      No [ ]

If yes, please give details:

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## Medical Conditions

Does the young person suffer from any medical condition or do they take prescription medication?

Yes [ ]      No [ ]

If yes, please give details:

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Does the young person have any specific dietary needs or restriction for health or cultural needs?

Yes [ ] No [ ]

If yes, please give details:

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N.H.S Number: \_\_\_\_\_ GP Name: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

### Additional information required on young person

Can you return this form & please attach any or all of the below listed (Please tick)

- Latest Care Plan
- Last Review Report
- Full Medical History
- Education History Including Schools
- Latest Educational Reports
- Counseling or Therapy Reports
- Any assessments completed on the young person from previous placement
- Any assessments completed by other agencies involved with young person
- YOT Reports

Any other comments:

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Pre Placement Meeting Arranged?

Yes [ ] No [ ]

If Yes, for what date and time? \_\_\_\_\_



## Young Person Initial Referral Form

Please note the information requested is required to enable Reflexion Care Group Limited to decide whether we are able to offer a placement that meets the needs of the young person. Should we agree in principle to progress with the referral and a placement is offered more detailed information will be obtained during a pre placement meeting where essential information will be recorded and form part of the young person's main file. Thank you for your enquiry, The Directors Reflexion Care Group Ltd – trading as New Reflexions

### Young Persons Details

Young Person Name: \_\_\_\_\_

Also Know As: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Legal Status: \_\_\_\_\_

Who Has Parental Responsibility: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Religion: \_\_\_\_\_

Nominal [  ] Practicing [  ]

Family Home Address: \_\_\_\_\_

Current Address: \_\_\_\_\_

### Social Worker Details

Name: \_\_\_\_\_

Team Manager: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Placing Authority: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone & Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

When would you like the placement to start? \_\_\_\_\_

How long would you like the placement to last? \_\_\_\_\_