# JUNO Women’s Aid

**South Nottinghamshire**

**Children and Teen Advocate Services**

**How to complete this referral:**

By completing this referral form, you’re helping us to make contact with the family/teenager as safely and quickly as possible. We’d appreciate it if you could include as much information as this saves the family/teenager from being asked the same questions twice and helps us to understand more about their particular needs and circumstances.

**If you have any questions please contact the Children and Teen Advocate Duty Desk on: 0115 8221777, Monday – Friday 9.00am – 5.00pm**

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| **How to submit this referral:** To submit your referral by email please ring beforehand for the password to protect your referral documents:**Email: childrenandteen@junowomensaid.org.uk**  |
| Alternatively you can post or fax your referral to:  | **Children and Teen Advocate Service****JUNO Women’s Aid****30 Chaucer Street****Nottingham****NG1 5LP****Fax: 0871 989 5486** |
| **Eligibility Criteria:**Children and teenagers who have witnessed or experienced domestic violence and abuse from the south of the county (Ashfield, Broxtowe, Gedling or Rushcliffe). **One to one support**:* The child must be aged 5 – 16 years (School years 1 – 11)
* The child has witnessed and has a memory of domestic violence and abuse within the home

**Group Work:*** The child must be aged 5 – 16 years (School years 1 – 11)
* The child has witnessed and has a memory of the domestic violence and abuse within the home

**Hands Are not For Hurting Programme:** * The child must be aged 5 – 16 years (School years 1 – 11)
* The child has witnessed and has a memory of domestic violence and abuse within the home
* The family are no longer living with the perpetrator and the relationship has ended
* Both mother and child attend group sessions and where possible are supported by the referrer to do so

**Teen Advocate Support:** * The teenager is aged 13-17 years (female and male) and has experienced abuse in their own intimate relationship
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| **Additional information to submit?** Early Help Assessment Form (EHAF), Teen DASH RIC and any other risk assessments that would support this referral. |
| **When we will respond:**The Children and Teen Advocate Service will respond to your referral within 2 working days. |

1. **Information about the person making the referral**

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| Date of referral:  | Click here to enter text. |
| **Please indicate which service you’d like to refer to:**  |
|  Click here to enter text.   |
| **Please enter your name and contact details:**  |
| Referrer’s name  |  Click here to enter text. |
| Organisation name  |  Click here to enter text. |
| Role/ job title  |  Click here to enter text. |
| Contact number  |  Click here to enter text. |
| Contact email  |  Click here to enter text. |
| **Consent:**  |
| Has the Child/teen given consent to have the referral?  | [ ]  Yes [ ]  No [ ]  Don’t Know  |

# 2. Child/Teenagers contact information

|  |
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| **Names**  |
| First name  |  Click here to enter text. |
| Last name  |  Click here to enter text. |
| Other names  |  Click here to enter text. |
| What do they like to be called?  |  Click here to enter text. |
| Date of Birth |  Click here to enter text. |
| **Contact info for this referral**  |
| Please contact:  | [ ]  Child or teenager directly[ ]  Parent/ Carer |
| *Details Safe to contact?*  |
| Phone  |  Click here to enter text. | [ ]  to call[ ]  to text[ ]  to leave voicemail  |
| Email  |  Click here to enter text. | [ ]  |
| Current address (inc. postcode) |  Click here to enter text. | [ ]  to post |
| Safe contact notes  |  Click here to enter text.  |
| **Mother/ carer contact information**  |
| Mother/carer name  |  Click here to enter text. |
| Date of Birth | Click here to enter text. |
| *Details Safe to contact?*  |
| Phone  |  Click here to enter text. | [ ]  to call[ ]  to text[ ]  to leave voicemail |
| Email  |  Click here to enter text. | [ ]  |
| Current address (inc. postcode) |  Click here to enter text. | [ ]  to post |
| Safe contact notes  | Click here to enter text. |
| **Next of kin – who can we contact in an emergency?**  |
| Name  | Click here to enter text. | Relationship | Click here to enter text. |
| Contact information  | Click here to enter text. |
| Safe contact notes  | Click here to enter text. |
| **Nursery/ School/ college/ info:**  |
| Click here to enter text. |
| **Safeguarding**  |
| Are children’s services involved in this case?  | [ ]  Yes [ ]  No [ ]  Don’t Know |
| Level/ nature of involvement – notes:  | Click here to enter text. |
| **Access requirements**  |
| Does this child/ teen have any access requirements (for example, braille documents)  | [ ]  Yes [ ]  No [ ]  Don’t Know  | *If yes, please provide details:* Click here to enter text. |
| Do they have any allergies?  | [ ]  Yes [ ]  No [ ]  Don’t Know  | *If yes, please provide details:* Click here to enter text. |
| Does this child/teen require an interpreter?  | [ ]  Yes [ ]  No [ ]  Don’t Know  | *If yes, please provide details:*Click here to enter text. |
| **Custody and contact arrangements** |
| Who has custody of this child/young person? | Click here to enter text. |
| Does the perpetrator have any contact with the child/young person? | [ ]  No contact with perpetrator [ ]  No formal contact arrangements in place[ ]  Perpetrator has sole custody[ ]  Perpetrator has supervised contact[ ]  Survivor has sole custody[ ]  Perpetrator has unsupervised contact |

1. **Child/Teenagers equalities monitoring**

|  |  |
| --- | --- |
| How would this child/teen describe their gender?  | [ ]  Female [ ]  Male [ ]  Other (*please specify):* Click here to enter text.[ ]  Don’t Know  |
| Is their current gender different to the sex they were assigned at birth?  | [ ]  Yes [ ]  No [ ]  Don’t Know  |
| The 2010 Equality Act defines disability as *‘a physical or mental impairment which has a substantial and long term adverse [negative] effect on their ability to carry out normal day to day activities’* |
| Based on the definition above, do they consider themselves to have any kind of disability? (please tick any that apply)  | [ ]  Physical [ ]  Learning [ ]  Mental Health  | [ ]  Deaf/ hearing impaired [ ]  Blind/ visually impaired [ ]  Other *(please specify):* Click here to enter text.[ ]  Don’t Know  |
| How would they describe their ethnicity?  |
| [ ]  White British [ ]  White Irish [ ]  White Gypsy or Irish Traveller [ ]  Any other White background [ ]  Asian British [ ]  Asian Indian [ ]  Asian Pakistani [ ]  Asian Bangladeshi [ ]  Any other Asian background [ ]  Chinese [ ]  Arab  | [ ]  White and Black Caribbean [ ]  White and Black African [ ]  White and Asian [ ]  Any other mixed/ multiple background [ ]  Black British [ ]  Black African [ ]  Black Caribbean [ ]  Any other Black background [ ]  Other *(please specify):*Click here to enter text.[ ]  Don’t Know  |
| Do they have a faith/ religion?  |
| [ ]  No religion [ ]  Bahai [ ]  Buddhist [ ]  Christian [ ]  Hindu [ ]  Jewish [ ]  Jain  | [ ]  Muslim [ ]  Shinto [ ]  Sikh [ ]  Zoroastrian [ ]  Other *(please specify):*  Click here to enter text. [ ]  Don’t Know  |
| What is their sexual orientation? *(if age appropriate)*  | [ ]  Heterosexual/ straight[ ]  Gay woman/ Lesbian [ ]  Gay man [ ]  Bisexual [ ]  Other *(please specify):* Click here to enter text. [ ]  Don’t Know  |

1. **Children/teenagers support needs/ vulnerabilities**

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| ***Please tell us more about any support needs the child/teen may have:***  |
| [ ] Mental Health [ ]  Physical Health [ ]  Sexual Health [ ]  Substance misuse [ ]  Aggressive behaviour [ ]  Self-harming/ suicidal feelings  | [ ]  Issues with educational attainment/ attendance [ ]  Social isolation [ ]  Bullying/ being bullied [ ]  Experiencing abuse [ ]  Other *(please specify below)*  |
| **Additional details:**  |
|  Click here to enter text.      |

# 5. Household Composition

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| **Please provide names and Date of Birth for any members of the household, including siblings below:**  |
| Name | DOB |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. |  Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

1. **Perpetrator’s Details**

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| --- |
| **Please provide name, address, date of birth (if known) of any perpetrators and details of their relationship to the child** |
| Name | Address | DOB | Relationship to child |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. |  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

# 7. Reason for referral

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| **Why are you making this referral – how could this child/teen benefit from our support?**  |
|  Click here to enter text.         |
| **Are there any known risks to working with this child/teen?**  |
| Click here to enter text. |
| **Are you including any of the following documents with your referral?**  |
| [ ]  Early Help Assessment (formally CAF)[ ]  Teen DASH RIC [ ]  Other *(please specify):* Click here to enter text.   |

Thanks for taking the time to complete this referral.

Before you send the referral, please check that your referral meets the criteria set out on the first page of this document, and that any relevant additional materials e.g. Early Help Assessment or Teen DASH RIC are attached. Please see coversheet for how to send this referral to the JUNO Women’s Aid Children and Teen Advocate Service.

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|  ***OFFICE USE ONLY***  |
| Modus ID:  |
| ***Referral outcome***  |
| Referral accepted?  | [ ]  Yes[ ]  No  |
| Allocated to:  |   |
| **Please complete if the referral was rejected**  |
| Reason for rejection  | [ ]  Unable to contact[ ]  Client does not want support [ ]  No space/ capacity to support [ ]  Ineligible for support (age) [ ]  Ineligible for support (borough/district/authority)[ ]  Ineligible for support (service description) [ ]  Unable to meet support needs around language[ ]  Unable to meet support needs around large family [ ]  Unable to meet support needs around mental health [ ]  Unable to meet support needs around disability [ ]  Unable to meet support needs around No Recourse to  Public Funds[ ]  Unable to meet support needs around drug and alcohol [ ]  Previous convictions for violent/sexual offences/ arson[ ]  Other  |
| Referred/ signposted on to:  | [ ]  Another refuge [ ]  Another specialist Violence Against Women and Girls  service [ ]  National Domestic Violence [ ]  Non-VAWG organisation/ service [ ]  Other  |