|  |
| --- |
| DOST PROFESSIONAL REFERRAL FORM  |
| ABOUT YOUNG PERSON |
| First Name |  |
| Family Name |  |
| Age |  |
| Date of Birth | Date | Month | Year |
|  |  |  |
| Age assessed DOB? |  |  |  |
| Their Country |  |
| Their First Language |  |
| Name of School or College |  |
| Sex/ identity | Male | Female | Transgender | Other identity |
| Level of English | Basic | Intermed | Advanced | Unknown |
| WHERE DO THEY LIVE? |
| Address  |  |
|  |
|  |
| Postcode  |  |
| Their Mobile Number |  |
| WHO DO THEY LIVE WITH? (tick 1) |
| Family |  |
| Foster carers |  |
| With friends |  |
| Hostel |  |
| Supported housing |  |
| Alone |  |
| EMERGENCY CONTACT |
| Name parent/ carer/ keyworker |  |
| Address  |  |
|  |
|  |
| Mobile Number |  |
| HEALTH |
| Health issues? | YES | NO |
| Details |  |
| Medication? |  |
| CONSENT |
| Does the young person know that you are making this referral? | YES | NO |
| OTHER PROFESSIONALS |
| Do they have a Social Worker? | YES | NO |
| Borough? |  |
| Do they have a solicitor? | YES | NO |
| Date of referral? |  |
| REASON FOR REFERRAL |
| Please say why you think the young person will benefit from attending Dost |  |
| RISK FACTORS |
| Please say if you are aware of any risk factors surrounding the young person attending - either for themself or for others,(trauma/ self-harm/ PTSD/ mental health issues/ violent tendencies)  |  |
| PROFESSIONALS INVOLVED |
| Please say which other professionals are involved with the young person and contact details if you have them |  |

**Please send us your referral form and we will contact you and the young person soon.**

**Email to** **marian@dostcentre.co.uk**

Or post to

**Marian Spiers**

**Youth Work Programme Manager**

**Newham Leisure Centre**

**281 Prince Regent Lane**

**London E13 8SD**