

**REFERRAL FORM – CONFIDENTIAL**

**Befriending Service**

Referred by: Date:

Based At: Address:

Email:

Telephone:

Are you a Social Worker in Training Yes/No?

If yes – name of person who will take up the case after your placement ends

Name of person:

Child’s Surname: Date of Birth:

First Name(s): Telephone:

Address: Mobile:

Usual Address: Telephone:

(if different from above)

Is the child on the Child Protection Register

or Subject to a Supervision Order? Yes /No

If 'Yes', under what category

Or conditions of the order?

Date child placed on Register or Order Implemented: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child any medical conditions or allergies we should be aware of? Yes/No

Is the child on any medication? Yes/No

If 'Yes', please provide details.

1. Medical Conditions/Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY DETAILS**

Primary Guardian / Carer

Name: Telephone:

Address: Mobile:

How many children under 16 reside in the family home? Please state name and age

Name Age

Sibling. 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sibing. 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sibling. 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Sibling. 4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

**NECESSARY INFORMATION  
It is essential that you provide as much accurate information as possible to ensure that an appropriate match can be made. A child may have more than one reason for referral.**

1. Reason for referral:

Low Self Confidence Behaviour Problems Parental Mental Health

Low Self-Esteem Abuse Child Mental health

Social Isolation  Child Substance Use Affected by Disability

Parental Substance use

In need of a Positive Adult Role Model

1. Please provide us with an outline of the child’s past and present circumstances, both home and in school, giving as much detail as possible on all issues affecting the child including behavioural problems.
2. Please list the child’s interests/Hobbies, including any pets in the family home.
3. Are the parent(s)/guardian and child fully aware of the service provided by Befriend a Child and what is their attitude towards volunteer involvement. How was this information provided?

Leaflet in Person

Please give details:

1. Is there any further information you feel may enhance this referral as failure to provide adequate information may cause the referral to be returned or rejected?

**Important Information**

Please submit an up to date Child’s Plan or Chronology which will allow Befriend a Child to have a better understanding of the child’s background. Failure to do so, may cause a delay in placing the child on the waiting list.

**CHILD REGISTRATION FORM - CONFIDENTIAL**

Child’s Surname: Date of Birth:

First Name (s):

Address:

1. **Main Contact – Primary Guardian/Carer information:**

Name: Name:

Address: Address:

Telephone: Telephone:

Mobile: Mobile:

E mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Emergency Contact if other than the above**

Name:

Address:

Telephone: Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor’s Details**

Name: Based at: \_\_\_\_\_\_\_

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

**School Details**

Name of School: Head Teacher:

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

**Referrer Details:**

Name: Telephone:

Team / Base: Senior:

**This Section to be completed by the child**

1. Are you happy to have a befriender? Yes / No

If yes. Please explain

1. 2. With a Befriender do you think you would:

Have fun Be happier Have new adventures

Listen and talk to them Visit new places Get to make new friends

1. 3. What else do you want to do with a befriender?
2. 4. Is there anything else you would like a befriender to know?

**This Section to be completed by the Parent / carer**

1. Has your child any known medical conditions we should be aware of? Yes/No

If 'Yes', please give details:

1. Medical Conditions/ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has your child any special dietary requirements? Yes/No

Please state:

3. WIII anyone other than a parent be present to assume responsibility for the child when the volunteer collects or drops off the child at the address given? Yes/No

If ‘Yes’, please state the name and relationship to the child:

Name: Relationship:

4. Is permission given for the volunteer/ staff to administer first aid/seek medical assistance for your child should the need arise if we cannot contact you? Yes /

1. Is permission given for your child to be taken out by the volunteer and to travel on public transport/volunteers’ cars? (Booster seats will be provided for younger children) Yes /

**IMPORTANT INFORMATION**

Should your child disclose any information, which suggests that their well-being or safety is in any danger or if they are at risk of abuse or neglect information will be passed on to Social Services.

At times the referrer may pass information to Befriend a Child about changes in your family circumstances should they arise. This information will only be shared with those involved in the child's welfare and confidentiality will be respect at all times.

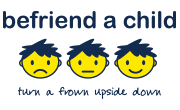
By signing this form, you agree to this information being shared.

**Declaration:**

**I confirm that I am the parent / carer for and hereby confirm that I have read, understood, and agree to questions 1, 2, 3, 4 & 5.**

**Signed: Date:**

**The volunteer has given a commitment of a minimum of 1 year to the Organisation and the child. If at any time you wish the befriending to stop you have the right to end the relationship by giving one month's notice. In this instance please contact the office on 01224 210060.**



**IMPORTANT**

***PLEASE READ CAREFULLY***

**COMMITMENT OF REFERRAL**

Befriend a Child is committed to providing and maintaining an optimum level of service to our users in Aberdeen and Aberdeenshire Therefore, in submitting this referral I agree to the following.

* **Inform the family when a suitable match has been found and explain the next steps to them**
* **Inform the family that they have the right to refuse the match should it be deemed unsuitable.**
* **Inform Befriend a Child of any changes in family circumstances and ensure that they are aware that information will be shared if necessary.**
* **Supply relevant information regarding the child progress to the Organisation before the volunteer's 6 monthly review takes place**.

**I have read and fully understand the terms and conditions of submitting this referral to Befriend a Child.**

Referrer's Signature

Print Name

Date

Please return to:

**Jean Gordon**

**Head of Operational Support Services**

**Befriend a Child**

**9 Bon Accord Square**

**Aberdeen**

**Befriend Child review the waiting list on a regular basis as per the Referral Policy guidelines. Children who are not matched after one year will be removed from the list. The referrer involved will be notified in writing should this occur.**

(for office only)

Date of receipt: Accepted: Yes/No

Date Ack. Sent: If no', reason:

Pease record any updated information

Date Received Received from Information Received