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**REFERRAL FOR THE PROJECT   
SUPPORTING YOUNG PEOPLE EXPERIENCING SOCIAL ISOLATION (11-19 YEARS OLD)**

(REFERRAL FORM TO BE COMPLETED BY THE REFERRER)

**Does the referrer have consent from parent/child to make this referral?**

Yes  No

**If yes, please continue with the referral form.**

**Local authority in which the participant of the project lives:**

|  |  |  |  |
| --- | --- | --- | --- |
| City of Edinburgh | East Lothian | Midlothian | West Lothian |

**Date of referral: ........................**

**Details of the referrer:**

|  |  |
| --- | --- |
| **Name of organisation/institution:** |  |
| **Address:** |  |
| **Name of person referring:** |  |
| **Telephone number and e-mail:** |  |

**Details of the referred child:**

|  |  |
| --- | --- |
| **Name and surname of the child:** |  |
| **Date of birth:** | DD / MM / YYYY Child’s age: ................. |
| **Sex:** |  |
| **Address:** |  |
| **Does the child consent to participate in the project?** | Yes  No |

**School details:**

|  |  |
| --- | --- |
| **Name and address of the school the child attends:** |  |
| **Name and surname of the Teacher:** |  |

|  |  |
| --- | --- |
| **Contact information to the Teacher/school:** | Telephone number: |
| Email: |

**Contact details of parent/carer:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and surname of the parent/carer:** |  | **Relation:** |  |
| **Address of parent/carer, if different from above:** |  | | |
| **Contact information of parent/carer:** | Telephone number: | | |
| Email: | | |
| **Does the parent/guardian consent for the child to participate in the project?** | Yes  No | | |

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| **QUESTIONS TO THE REFERRER:**  **Does the child face any of the challenges stated below, please tick appropriate?** |
| School problems, please state ................................................................................  …………………………………………………….……………………………………………  ………………………………………………………….……………………………………...  Family relations problems  Low self-confidence, low self-esteem  Social isolation, loneliness  Addictions, please state ............................................................................................  Depression  Stress and anxiety  Other, please state ....................................................................................................  …………………………………………………………….…………………………………….. |
| **Please tick, what best describes the child’s behaviour** |
| Shy, closed off  Does not establish relations with peers  Often stressed and/or anxious  Has difficulties to settle in new situations  Does not want to attend school  Suicide attempts in the past  Other, please state ...................................................................................................................  …………………………………………………………………………………………………………….. |
| **Please state, when the above concerning behaviour began to occur, tick appropriate.** |
| 0-3 months  3-6 months  More than 6 months |
| **Please tick, which of the support services below would be most suitable for the child’s needs** |
| Individual psychological consultations  Individual family and/or peers support  Support groups with peers  Psychological and/or educational workshops |

**Short description of the reason for the referral, please include concerns regarding the child.**

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Completed referral should be send to the following email address: [ReceptionDesk@pfsc.co.uk](mailto:ReceptionDesk@pfsc.co.uk)

or posted to Polish Family Support Centre. Office address: 19 Smith’s Place, EH6 8NU Edinburgh.

All information contained in this referral is confidential and will only be available for inspection by the professionals of the Polish Family Support Centre in Edinburgh, according to the Data Protection Act 2018 and the PFSC Privacy Policy.