**PARACHUTE PROGRAMME REFERRAL FORM**

**Important Information**

* Parachute is a programme for 11–19-year-olds who have been identified as needing help in managing conflict in their relationships. Parachute is aimed at young people who may already have a history of resorting to violence to try and solve conflict. They may have a history of frequent conflict at home, in their relationships or at school.
* Parachute sessions usually take place within school/college on a 1:1 basis.

*(Occasionally group sessions may be offered at an external venue such the WISH centre.)*

* Face-to-Face and Hybrid/Remote sessions can be accommodated.
* We can offer Parachute to Young People in Blackburn with Darwen, and Lancashire.
* There will be 1 session per week for 10 weeks. Each session takes up to an hour.
* If there is current risk, then please ensure that the appropriate safeguarding procedures have been followed.
* ***SCHOOLS*** - For schools who wish to make multiple referrals, we can offer to facilitate a school group programme for up to 4 students at a time. Groups will be run apposite to their year group – Year 7-8 and Year 9-11. Please indicate in the tick box if this is something you are interested in.

**Before completing the referral, please ensure the following:**

|  |  |
| --- | --- |
| **The parent/ carer is fully supportive of the referral (under 16 only).** | YES [ ]  |
| **The school/college are able to accommodate the sessions.** | YES [ ]  |
| **The service has been discussed with the young person and are they willing to engage?** | YES [ ]  |
| **Please indicate in which settings you are happy for the young person to engage with Parachute?****Please note, that facilitating of a school group with up to 4 students can be discussed.**  | Face to Face - Individual [ ] Face to Face – Group  [ ] Online - Individual [ ] Online – Hybrid Group [ ] School Group [ ]  |

**Referrer’s details**

|  |  |
| --- | --- |
| Name  |  |
| Job role / relationship to YP |  |
| Agency / organisation |  |
| Address |  |
| Contact number |  |
| Email address |  |

**Child / young person’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Young Person’s name |  | AGE and DOB |  |
| Address |  | Gender |  |
| Consent from young person? |  | Tel. no |  |
| What is their current School Year? | [ ]  Year 7-8[ ]  Year 9-11 |

**Parent / carer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent / carer’s name |  | Legal status (parent, carer, etc.)? |  |
| Address  |  | Consent obtained? (if child is under 16) |  |
| Tel. Number |  | Email address |  |

**Details of family structure and relationships (eg siblings, other parent/carers, young person’s relationships, does the young person have any children? Is there anyone that the YP is not allowed contact with?)**

|  |
| --- |
|  |

**Ethnicity**

|  |  |
| --- | --- |
| White British |[ ]  British Asian |[ ]
| Asian - Indian |[ ]  Asian - Pakistani |[ ]
| British Caribbean |[ ]  Black Caribbean |[ ]
| Dual heritage, please specify: |[ ]  Other, please specify: |[ ]

**Sexuality**

|  |  |
| --- | --- |
| Heterosexual |[ ]  Gay |[ ]
| Lesbian |[ ]  Bisexual |[ ]
| Other |[ ]  Prefer not to say |[ ]

**School / college**

|  |  |
| --- | --- |
| Name of school / college |  |
| Contact name & details |  |

**GP**

|  |  |
| --- | --- |
| GP name |  |
| Surgery |  |
| Tel no |  |

**Continuum of need**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CAF/early help |[ ]  Lead Professional |  | Tel. |  |
| Child in Need |[ ]  Social Worker |  | Tel. |  |
| Child Protection |[ ]  Social Worker |  | Tel. |  |

**Has the case been heard at MARAC?** If yes, when? .............................................................

**Support Structure – any other professionals involved**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Role | Agency | Tel |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Reason for referral – please provide as much detail as possible.**

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| --- |
|  |

**Coping strategies (e.g. self-harm, drugs etc)**

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| --- |
|  |

**Any risk to self / others**

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| --- |
|  |

**Disabilities / any additional support needs identified / allergies/ any current medications**

|  |
| --- |
|  |

**Young Person’s Voice –** (where possible in the YP’s words- What does the YP want to achieve from the referral? How does the YP feel about the referral? Is there anything else that the YP wants to tell us?)

|  |
| --- |
|  |

**Signed (referrer) ……………………………………………………….……. Date………………………**

**Signed (parent / carer) …………………………..……………………….. Date………………………**

**Signed (child / young person) ………………………………………….. Date………………………**

Please return the completed form to:

* Email: info@thewishcentre.org
* Fax: 01254 269598

**For information on how we use and store your data please visit** [**https://www.thewishcentre.org/get-involved**](https://www.thewishcentre.org/get-involved)

**Or contact the WISH centre via the details above.**

**Office Use Only**

**Received on: / / Added to database: / /**

**Reference Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**