



Community **Youth** Teams

# YOUNG PERSON REFERRAL FORM

(age 16 plus only)



South Yorkshire  
**POLICE**



# COMMUNITY YOUTH TEAMS

This referral form is for you to complete if you feel you need additional support to make better choices for your future.  
Once completed return the form to:

CYT  
Floor 3, Star House  
43 Division Street  
Sheffield  
S1 4GE

and/or

[cyt@sheffield.gcsx.gov.uk](mailto:cyt@sheffield.gcsx.gov.uk)

Tel: 0800 138 8381 Fax: 0114 244 2327  
all CYT referral forms are available on the website [www.sheffield.gov.uk/cyt](http://www.sheffield.gov.uk/cyt)

## YOUR DETAILS:

Family Name:		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
First Name:		Address:	
Age:		Postcode:	
Date of Birth:		Telephone No:	
1 <sup>st</sup> Language:		Interpreter Needed:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Looked After Child?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

## Parent or Main Carer(s)

Full Name:		Date of Birth:	
Relationship:		Address if different:	
		Telephone No:	

## Name of School/College (if applicable):

Key school staff involved (if applicable):		Contact Details:	
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## Ethnicity:

White – British <input type="checkbox"/>	White – Irish <input type="checkbox"/>	Roma <input type="checkbox"/>
Eastern European <input type="checkbox"/>	Any Other White Background <input type="checkbox"/>	White & Black Caribbean <input type="checkbox"/>
White & Black African <input type="checkbox"/>	White and Asian <input type="checkbox"/>	Any Other Mixed Background <input type="checkbox"/>
Asian – Indian <input type="checkbox"/>	Asian – Pakistan <input type="checkbox"/>	Asian – Bangladeshi <input type="checkbox"/>
Any Other Asian Background <input type="checkbox"/>	Black – Caribbean <input type="checkbox"/>	Black – African <input type="checkbox"/>
Somali <input type="checkbox"/>	Yemeni <input type="checkbox"/>	Chinese <input type="checkbox"/>
Any other ethnic group:.....		Prefer not to say / not stated <input type="checkbox"/>

## WHAT ARE YOU WORRIED ABOUT?

Not going to School or College?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Not working?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drinking too much?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Taking Drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hanging around with the wrong people?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I'm in a situation I can't deal with?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Getting stopped by the Police?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### Please give us some more details about what you are most worried about:

How do you want to be contacted?	Post <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/>
Email Address:	Mobile Phone Number:
Do you need any other additional support? E.g. housing/benefits/other. If yes please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you would also like further information about youth clubs or activities in your area please let us know and we will send you the details:	Yes <input type="checkbox"/> No <input type="checkbox"/>

## YOUR CONSENT:

Are you willing to work with the Community Youth Team?    Yes     No

If you are under 16, for some of our services, we need to have permission from your parent/carer to work with you, is this ok?    Yes     No

- I agree that the information on this form and other relevant information held by partner agencies may be shared for the purpose of deciding which support is appropriate. The agencies involved are: Community Youth Teams, Children & Young People and Families (SCC), Housing, Police, Health Services (including CAMHS), School and other voluntary and community agencies.

Signed: \_\_\_\_\_ Name: \_\_\_\_\_  
Date: \_\_\_\_\_