



Community **Youth** Teams

GROUP REFERRAL FORM

<i>Completed referrals to:</i>	
Post	CYT Floor 3, Star House 43 Division Street Sheffield S1 4GE
Email	cyt@sheffield.gcsx.gov.uk
Fax	0114 203 5153
For information or queries contact our Freephone number or visit our website	0800 138 8381 www.sheffield.gov.uk/cyt



REFERRAL DETAILS:

What are the main issues or concerns surrounding this group of young people that you would like CYT to address? *Please include the behaviours of concern, any specific incidents and if there are any risks with the group working together.*

SUMMARY OF GROUP REFERRAL AND FURTHER DETAILS

Please include any previous or current contact/support with any of the young people listed, i.e. previous involvement with CYT, Youth Justice Service, MAST etc. Include any recent referrals to other agencies.

CONSENT

- Please complete the following sheet and gain consent from **all** parents/carers and young people involved in this group referral.
- A meeting will take place between CYT staff and the referrer prior to starting the group-work to ascertain the content and level of the programme and risk assessment.

Parent/Carer Consent:

- I have had the referral process explained to me and I agree to this referral.
- I understand that this may involve an assessment of my child's needs in order that appropriate support is planned.
- 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 _____ (Parent/Carer) Date _____

Signed _____ (Parent/Carer) Date _____

Young person's consent:

Name: _____

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

Signed _____ (Young person)

Date _____

Parent/Carer Consent:

- * I have had the referral process explained to me and I agree to this referral.
- * I understand that this may involve an assessment of my child's needs in order that appropriate support is planned.
- * 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 _____ (Parent/Carer) Date _____

Signed _____ (Parent/Carer) Date _____

Young person's consent:

Name: _____

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

Signed _____ (Young person)

Date _____