**Bay Young Persons Social Prescribing Referral Form**

Young Persons social prescribers can accept referrals for people aged 11 and up to and including people aged 19 who are registered with Bay Medical Group.

Social prescribing can help support people to make lifestyle changes, connect with groups and activities in the community and includes supportive person-centred conversations to help improve health and wellbeing. We will make contact with the young person and arrange to meet them at an agreed community venue or provide telephone support. We aim to work with young people to understand what matters to them and provide support to empower young people to reach their goals.

We are unable to accept referrals for people who:

* Are experiencing suicidal ideation
* Have significant forensic history particularly including violent and sexual offenses *(NB this criterion will be reviewed on a case-by-case basis)*
* Have care-coordination already in place from mental health services
* Are receiving current support or have met the criteria for and are awaiting an appointment from the Child and Adolescent Mental Health service

**Please note this is not a mental health or emergency service and whilst we aim to make initial contact within 10 working days this may vary depending on case load.**

**IF YOU HAVE SAFEGUARDING CONCERNS, PLEASE RAISE THESE IMMEDIATELY THROUGH APPROPRIATE CHANNELS - Call 0300 123 6720 or out of hours 0300 123 6722**

**IF YOU FEEL THE YOUNG PERSON IS IN IMMEDIATE DANGER, PLEASE CALL 999.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient details:** | | | |
| **Date of Referral** |  | | |
| **Person's name**  (Please include preferred name if different) |  | | |
| **Date of Birth** |  | | |
| **Contact details for person being referred** |  | | |
| **Home Address** |  | | |
| **Is person a patient of Bay Medical Group?** | No | Yes | Unknown or not registered with a GP |
| **Please provide details of any additional needs:** |  | | |
| **Consent** | | | |
| **Has the person consented to the referral?** | No | Yes  Verbal / Written consent given | |
| **If under 16 has parent/guardian consent been obtained?** | No | Yes | N/A - Person has been assessed and is Gillick Competent |
| **Reason for referral** | | | |
| *Please provide details of the reason for referral including the support that the person would like to receive:* | | | |
| **Other support in place** | | | |
| **Please provide details of any known safeguarding issues or current early help assessment (EHA) plans (formerly CAF) - if unknown please state** | | | |
| **Referrer details** | | | |
| **Name of referrer** |  | | |
| **Organisation & role** |  | | |
| **Telephone contact** |  | | |
| **Email** *(if different from one used to make this referral)* |  | | |

* Please return this form via email to [bay.icc@mbht.nhs.uk](mailto:bay.icc@mbht.nhs.uk)- Your referral will be acknowledged and we will contact the young person as soon as possible. Please remember this is not an urgent or crisis service.
* Please ensure information is sent securely to us, you can do this by adding the text **[secure]** into the subject line of your email.
* Bay Medical Group staff can task referrals to the ‘care-coordination’ inbox via EMIS – please include details of the consent and reason for referral section of this form in your task.
* If you would like to informally discuss a possible referral, please email [youngpersonssp@gmail.com](mailto:youngpersonssp@gmail.com) or call Maxine on 07485 317731 or Lukas on 07480 965526

There may be circumstance that we are unable to accept your referral, this will be communicated back to the person who made the referral.