**CHECKLIST** **Name of young person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ensure the child you are referring meets the eligibility and referral criteria below. **Please tick** **any service limitations.**

**Eligibility:**

**All** boxes **must** be ticked for the young person being referred.

1 The young person lives in the Forest of Dean, is aged **11-18 years** (year 6 and above)**.**

2 They can build a relationship based mainly on conversation.

3 You have explained to them how our mentoring programme works, what is expected of them, and you believe they have understood this.

4 They want to be involved in our mentoring programme as described.

5 They are willing to commit to 1- 2 hours weekly on a weekday for 1 year.

1. Disruptive in class or struggling to engage in education, excluded or at risk of exclusion from education or not in education training or employment NEET.

**Referral**

**Criteria:**

Applicants must meet at least two risk factors. Tick each relevant box.

1. Low self-esteem/lacking confidence.

3 Displaying signs of antisocial behaviour/at risk of offending.

4 In or leaving care.

5 Experiencing challenges out of school, e.g. lack of role model, family breakdown, bereavement, isolation, historic domestic violence, abuse.

**Service Limitations:**

If any of these limitations apply, we would need to discuss these before accepting a referral.

1 Their behaviour presents a risk to a volunteer mentoring them.

2 They have significant challenges requiring support not in place.

3 They have severe learning difficulties or an EHCP in place.

4 They have significant mental health problems.

5 They or the parents/carer they live with have a history of violence.

6 They have accessed our mentoring service in the last 12 months.

7 None of the above service limitations apply.

1. **DETAILS OF YOUNG PERSON**

Name(s): Date of Birth: Gender:

Address:

Post code:

Telephone No (Home): (Mobile):

Ethnic background: Languages spoken:

Name of school/College:

🞎 Regular school attendance. 🞎 Persistent non-school attendance.

🞎 Permanently excluded. 🞎 Attending alternative education provision.

Health Information (if relevant):

Emotional and Behavioural development/Difficulties (If relevant)

Name of Parent/carer:

(Mobile): Email:

Address if different from above:

1. **REFERRING AGENCY**

Name, and role of person making referral:

Agency & address:

Post code: Tel No:  Mobile: Email:

Reason for your involvement:

Date of referral:

Any other known agencies working with YP (and reasons for involvement if known):

Agency (Name and Tel):

Reason (If known):

1. **REASON FOR REFERRAL:**

Why is the YP being referred to Breathe Mentoring?

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What are the main areas of concern? Is the YP at significant risk?

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What are the best methods for engagement with YP? (e.g.: skills, interests, working in groups/individually)

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|  |

1. **AREAS OF DEVELOPMENT:**

What support is the YP currently receiving (or received in the past)? Include what has not worked, or has worked well.

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| --- |
|  |

In which areas do you feel the YP could benefit from support/development (e.g.: Goal setting, help with school, friendships and relationship, self-esteem, etc)?

|  |
| --- |
|  |

1. **DECLARATIONS (Person In Need Of Support) AND DATA PROTECTION AND GDPR**

Any data provided in this form will be stored and processed in accordance with the Data Protection Act 1998 and GDPR 2018 and used for various administrative and health and safety purposes. For details, check our [Privacy Notice](https://www.breatheyouth.org.uk/privacy-notice/) on our website.

I understand that when the Mentor Coordinator meets with the young person and parent/carer to discuss the referral, a separate consent form will be completed that specifically covers the storage and processing of their personal information within Breathe.

**Important**: **Breathe will not be able to process this referral unless signed by both the parent/carer and young person.**

Breathe Mentoring service has been discussed with me and I am happy for a referral to be made to this service.

**Signature of parent/carer (If YP is under 16): ............................................................... Date: ......................**

**Signature of YP: ……………………………………………….......................................................... Date: ……..….…………**

**Signature of person making the referral: ……………………................................................ Date: …………..….…...**

**Please send completed form and checklist to:** Ruth Julius, Mentor Coordinator, Breathe, c/o 11 Princess Royal Road, Bream, Lydney, Glos GL15 6NG or obtain **signatures, scan and email securely** to: [rjulius@breatheyouth.org.uk](mailto:rjulius@breatheyouth.org.uk) 07738 422831

**OFFICE USE**

Referral received: BY Reference No:

First Contact: Matching Meeting:

1st Session started: