**WEST HAM UNITED FOUNDATION PCN REFERRAL FORM**

**Please complete and email to:** [**nelondonicb.whureferrals@nhs.net**](mailto:nelondonicb.whureferrals@nhs.net)

|  |  |
| --- | --- |
| Child/Young Person’s Name |  |
| Gender (how does the child/young person identify?) |  |
| Date of Birth |  |
| Contact number |  |
| Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnicity** | | | |
| Arab |  | Any other Asian background |  |
| Bangladeshi |  | Any other Black/African/Caribbean background |  |
| Black African |  | Any other ethnic group |  |
| Black Caribbean |  | Any other Mixed/Multiple ethnic background |  |
| Chinese |  | Any other White background |  |
| Gypsy or Irish Traveller |  | White and Asian |  |
| Indian |  | White and Black African |  |
| Irish |  | White and Black Caribbean |  |
| Pakistani |  | White English/Welsh/Scottish/Northern Irish/British |  |
| Unknown/Not stated |  |  |  |

|  |  |
| --- | --- |
| Parent/Carer Name |  |
| Relationship to young person |  |
| Contact number |  |
| Email address |  |

|  |  |
| --- | --- |
| Name of School/College/University (if applicable) |  |
| Main school contact (if known): |  |

|  |  |
| --- | --- |
| Registered GP Practice |  |

|  |  |
| --- | --- |
| Details for referral. Please share as much information as possible |  |

|  |  |
| --- | --- |
| **SAFEGUARDING CONCERNS/NEEDS** | |
| Are there any ongoing or past safeguarding concerns, WHUF need to be aware of in order to support the young person and maintain their safety or the safety of others/staff?  This can include:   * Mental Health concerns (suicidal tendencies, depression or self-harm etc) * Learning needs (ADHD, Autism, EHCP Plan, Speech & Language Need) * Physical disability * Medical diagnosis * Drug or alcohol abuse * Known to commit acts of violence/aggression against others and/or property or be a victim of aggression/intimidation? * Affiliated with individuals known to be actively involved in CSE, CCE, and/or gang activity, or is the child believed to be a victim, or vulnerable to this in any way? * Known associates involved in extremism or radicalisation? | |
|  | |
| Does the child/young person take any prescribed medication, or have any allergies? | |
| Yes/No/Unknown | If Yes, please expand below: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Looked After Child |  | Child Protection Plan |  | Child in Need |  |
| If yes, please expand below: | | | | | |

|  |  |
| --- | --- |
| Has the service been explained to the parent/carer | Yes/No, please include date: |

|  |  |
| --- | --- |
| Name of Person completing this referral |  |
| Name of Organisation and Role |  |
| Signature |  |
| Date |  |

**WEST HAM UNITED FOUNDATION – CONSENT AGREEMENT**

I understand that information provided to the West Ham United (WHU) Foundation and the NHS will be securely recorded and handled in accordance with the General Data Protection Regulation 2018 and the Data Protection Act 2018.

I understand that the majority of the data the WHU Foundation and the NHS holds is mandatory (as required by law) and the rest is submitted by family of their own free will.

I give my consent for the WHU Foundation and the NHS to hold the voluntarily provided information and to use it for the purpose of ensuring the safety and wellbeing of the child/young person to whom this consent form applies, as well as the safety and wellbeing of staff, volunteers and other participants. I understand that this information will be only be shared with appropriate third parties where it is either legally required to do so or where my consent has been given.

I am aware that the NHS will look into the vulnerabilities and medical conditions of the child/young person to whom this consent form applies. This information will be shared with the WHU Foundation to ensure the safety and wellbeing of all participants and staff, and to provide individuals with the appropriate support that they may need. The information will also be shared to the NHS from WHU Foundation if it’s required by the agreement to protect vulnerable persons.

The act of signing this form provides consent to the above and confirms that the child/young person has voluntarily agreed to be referred to the WHU Foundation.

|  |  |
| --- | --- |
| Name of Child/Young Person to whom this consent form applies |  |
| Signature |  |
| Date |  |

|  |  |
| --- | --- |
| Name of Parent/Guardian |  |
| Signature |  |
| Date |  |