

**ISPCC CHILDLINE DMHWBP REFERRAL FORM FOR NON-CLINICAL REFERRERS (e.g., parents/carers & teachers)**

**DIGITAL MENTAL HEALTH AND WELLBEING PROGRAMMES DELIVERED VIA THE SILVERCLOUD PLATFORM**

**Please indicate to which programme you wish to refer by placing X in the relevant box/es:**

[ ]  **Space From Anxiety (Child and Young Person programme: 15–18-year-old young persons) \* (14-year-olds accepted if deemed appropriate by referring Clinician only).**

[ ]  **Supporting An Anxious Child aged 5 – 11 years old (Parent/Carer programme)**

[ ]  **Supporting An Anxious Teen aged 12 -18 years old (Parent/Carer programme)**

**PLEASE NOTE: ONLY COMPLETE REFERRAL FORMS WILL BE CONSIDERED**

**ACCEPTANCE THRESHOLD: CLIENTS WILL BE ACCEPTED INTO THE PROGRAMME ON THE BASIS OF THE FOLLOWING THRESHOLDS: PLEASE NOTE THAT ANSWERING “YES” TO CERTAIN QUESTIONS MAY PRECLUDE THE REFERRED FROM ENGAGING IN THE PROGRAMMES.**

**DETAILS OF PERSON/S BEING REFERRED (ONLY ENTER YOUNG PERSON’S DETAILS IF ACCESSING THE *SPACE FROM ANXIETY* PROGRAMME).**

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| **NAME OF YOUNG PERSON BEING REFERRED INTO THE SERVICE:** | **NAME OF PARENT/CARER BEING REFERRED INTO THE SERVICE:** |
| **DATE OF BIRTH OF YOUNG PERSON BEING REFERRED INTO THE SERVICE:** | **DATE OF BIRTH NOT NEEDED FOR PARENTS/CARERS** |
| **ADDRESS OF YOUNG PERSON BEING REFERRED INTO THE SERVICE:** | **ADDRESS OF PARENT/CARER BEING REFERRED INTO THE SERVICE:** |
| **EMAIL ADDRESS OF YOUNG PERSON BEING REFERRED INTO THE SERVICE (WE CANNOT ACCEPT REFERRALS WITHOUT EMAIL ADDRESSES):** | **EMAIL ADDRESS OF PARENT/CARER BEING REFERRED INTO THE SERVICE (WE CANNOT ACCEPT REFERRALS WITHOUT EMAIL ADDRESSES):** |
| **CONTACT NUMBER OF YOUNG PERSON BEING REFERRED INTO THE SERVICE** **(WE CANNOT ACCEPT REFERRALS WITHOUT CONTACT NUMBERS):** | **CONTACT NUMBER OF PARENT/CARER BEING REFERRED INTO THE SERVICE (WE CANNOT** **ACCEPT REFERRALS WITHOUT CONTACT NUMBERS):** |
| **PREFERRED PRONOUNS OF YOUNG PERSON BEING REFERRED INTO THE SERVICE:** | **PREFERRED PRONOUNS PARENT/CARER BEING REFERRED INTO THE SERVICE:** |
| **PRIMARY REASON FOR REFERRAL (please provide as much details as possible in order for the ISPCC to assess suitability for the service):** | **PRIMARY REASON FOR REFERRAL (please provide as much details as possible in order for the ISPCC to assess suitability for the service):** |

**ACCEPTANCE THRESHOLD: CLIENTS WILL BE ACCEPTED INTO THE PROGRAMME ON THE BASIS OF THE FOLLOWING CRITERIA: PLEASE NOTE THAT ANSWERING “YES” TO CERTAIN QUESTIONS MAY PRECLUDE THE REFERRED FROM ENGAGING IN THE SERVICE AND SOME ANSWERS MAY NEED FURTHER CLARIFICATION.**

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| **DOES REFERRED OR THEIR CHILD FIT WITHIN LOW TO MODERATE ANXIETY LEVELS? (e.g., may be showing signs of worry, negative thoughts, avoidance however, can still take part in daily activities)** | **YES:** [ ]  **NO:** [ ] **IF NO, PLEASE PROVIDE DETAILS:** |
| **DOES REFERRED OR THEIR CHILD HAVE A HISTORY OF/CURRENTLY EXPERIENCING SUICIDAL DISTRESS OR ENGAGING IN SELF-HARMING BEHAVIOURS. (If yes, are there currently supports in place/has support been sought at time of occurrence? When was the most recent occurrence?)** | **YES:** [ ]  **NO:** [ ] **IF YES, PLEASE PROVIDE DETAILS:** |
| **DOES THE REFERRED OR THEIR CHILD HAVE EXPERIENCE OF BULLYING OR DISCRIMINATION (e.g., due to gender, marital status, sexual orientation, race, ethnicity, age, disability, religion, minority group)** | **YES:** [ ]  **NO:** [ ] **IF YES, PLEASE PROVIDE DETAILS:** |
| **DOES THE REFERRED OR THEIR CHILD HAVE A HISTORY OF/CURRENTLY ENGAGING IN DRUG OR ALCOHOL MISUSE?** | **YES:** [ ]  **NO:** [ ] **IF YES, PLEASE PROVIDE DETAILS:** |
| **DOES THE REFERRED OR THEIR CHILD HAVE A HISTORY OF ABUSE?** **IS THERE A CURRENT INVESTIGATION OR TREATMENT ONGOING?****HAS A PROFESSIONAL ASSESSMENT OR TREATMENT TAKEN PLACE?** | **YES:** [ ]  **NO:** [ ] **YES:** [ ]  **NO:** [ ] **YES:** [ ]  **NO:** [ ] **IF ANSWERED YES TO ANY OF THESE QUESTIONS, PLEASE PROVIDE DETAILS:** |

**PLEASE ANSWER THE FOLLOWING QUESTIONS IF REFERRING A YOUNG PERSON INTO THE *SPACE FROM ANXIETY* PROGRAMME. THIS IS AN ONLINE, SELF-DIRECTED PROGRAMME.**

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| **DOES THE YOUNG PERSON BEING REFERRED HAVE THE REQUIRED EQUIPMENT (tablet/ smartphone/ computer; internet) AND SKILLS TO ENGAGE IN AN ONLINE PROGRAMME?** | **YES:** [ ]  **NO:** [ ] **COMMENTS:** |
| **DOES THE YOUNG PERSON BEING REFERRED HAVE THE REQUIRED READING AGE OF 12 YEARS OF AGE?** | **YES:** [ ]  **NO:** [ ] **COMMENTS:** |
| **DOES THE YOUNG PERSON BEING REFERRED HAVE GOOD LEVEL OF MOTIVATION IN ORDER TO ENGAGE WITH A SELF-DIRECTED, ONLINE PROGRAMME?** | **YES:** [ ]  **NO:** [ ] **COMMENTS:** |

**PARENTAL CONSENT FOR THE *SPACE FROM ANXIETY* PROGRAMME**

|  |  |
| --- | --- |
| **NAME OF PARENT/CARER:** |  |
| **RELATIONSHIP TO THE CHILD:** |  |
| **(NB) EMAIL ADDRESS:** |  |
| **(NB) CONTACT NUMBER:** |  |
| **HAS THE PARENT/CARER PROVIDED WRITTEN OR VERBAL CONSENT? \*** | **YES:** [ ]  **NO:** [ ]  |
| **DATE CONSENT WAS PROVIDED:** |  |

*\*Please note: consent covers consent for the child’s involvement in the programme as well as consent to be contacted by the ISPCC to set up the delivery of the support programme.*

**REFERRER DETAILS (PLEASE COMPLETE IN FULL FOR REFERRAL TO BE CONSIDERED)**

|  |  |
| --- | --- |
| **NAME OF REFERRER:** |  |
| **ROLE:** |  |
| **AGENCY/SETTING AND ADDRESS:** |  |
| **CONTACT NUMBER:** |  |
| **EMAIL ADDRESS:** |  |
| **ARE FAMILY AWARE REFERRAL HAS BEEN MADE?** | **YES:** [ ]  **NO:** [ ] **IF NOT, PLEASE STATE WHY:** |
| **HAS THE REFERRED OR THEIR PARENT PROVIDED WRITTEN OR VERBAL INFORMED CONSENT TO ENGAGE IN THE DMHWBP SERVICE?** | **YES:** [ ]  **NO:** [ ] **DATE CONSENT WAS GIVEN:** |

**REFERRER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please email the completed referral form to:**

**spacefromanxiety@ispcc.ie**

**Alternatively, please post the completed referral form to:**

**Danielle Ginty**

**ISPCC**

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