

**Respond
Referral for Risk Assessment**

Client Details:

Surname..... First name(s).....

Date of Birth..... Gender.....

Address.....

.....

.....

Tel no.....

Referrer Details:

Name.....

Organisation / Agency

.....

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Address

.....

.....

.....

Tel no.

Signature.....Date

Client Support Network

Name..... Position.....

Address.....

Tel no.....

Name..... Position.....

Address.....

Tel no.....

Name..... Position.....

Address.....

Tel no.....

Name..... Position.....

Address.....

Tel no.....

Name..... Position.....

Address.....

Tel no.....

Funding Authority.....

Funding Officer.....

Address.....

Tel no.....

Ethnic Classification:

White

- British
- Irish
- Any other white background

Black/Black British

- Caribbean
- African
- Any other black background

Chinese or other ethnic group

- Chinese
- Any other

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

First Language:

Other means of communicating:.....

.....
.....

Level of Learning Disability

Please include relevant information on verbal/non-verbal communication

Reason for referral:

Prior to this referral, have there been any previous concerns about the Client's sexual behaviour?

Yes

No

Don't know

If yes, please describe:

Denial / Admittance

Does the client	Yes	No	Don't know
Completely deny any sexually abusive behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Admit they abused but significantly minimises Extent or duration of abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substantially admit to the allegation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please give first names of victims admitted to:			
Has the client ever been convicted of a Schedule 1 Offence(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please give details:			

Details of (alleged) victim(s)

Gender..... Age.....

Relationship to the alleged abuser

Family Member	<input type="checkbox"/>	Friend / Acquaintance	<input type="checkbox"/>
Stranger	<input type="checkbox"/>	Don't know	<input type="checkbox"/>

Have you access to witness statements or records of interview with victim/alleged victim?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Case History

Please indicate whether any of the following apply to the client

	Current	Previous	Never	Don't know
Accommodation by voluntary Agreement with parents (S20 Children Act 1989)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subject to a Care Order (S31 Children Act 1989)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remand to LA Accommodation (S23(1) Children and Young Person's Act 1969)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
His/her name has been placed on the Child Protection Register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
His/her children's name has been placed on the Child Protection Register	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other referrals to or contact with Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Social Services involvement with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the client ceased to be looked after within the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Details including placement details (where applicable)				

Abuse History

	Yes	No	Suspected	Unknown
Is the client:				
Known to have been sexually abused (ie. disclosed)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspected of being sexually abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically abused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionally abused or neglected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete only where sexual abuse is known or suspected:

Age when sexually abused (years)	0-5 <input type="checkbox"/>	6-10 <input type="checkbox"/>	11-17 <input type="checkbox"/>	not known <input type="checkbox"/>
Duration of abuse	Under 6 months <input type="checkbox"/>	Over 6 months <input type="checkbox"/>	not known <input type="checkbox"/>	
Age of perpetrator at time of abuse	Child (0-12 yrs) <input type="checkbox"/>	Adolescent (13-17 yrs) <input type="checkbox"/>	Adult (18+) <input type="checkbox"/>	
Sex of perpetrator	Male <input type="checkbox"/>	Female <input type="checkbox"/>		
Relationship of abuser to victim eg. father, grandfather				
Are there any other known/suspected abusers in the family?				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
If yes, please say whom:				
Has the client's family been involved with Social Services before current referral?				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
If yes, please say why?				

Criminal History	Known	Yes / No
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Offence	Date	Disposal (include cautions)

Living Arrangements

With whom has the client been mostly living over the last 6 months?

Mother Father Foster Carer(s)
 Adoptive parents Siblings Grandparents
 Step parent(s) Other family By self
 Partner Friends Own child(ren)
 Resident of home / institution Other adults

If his / her living arrangements are different, please specify below:

Family Details:

Name	Relationship	Address
.....
.....
.....
.....
.....
.....

Please indicate whether an of the following apply to the client:

Usually Currently Don't Know

Living with known offender(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Absconding or staying away, eg. ever reported as a missing person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganised/Chaotic, eg different people coming or going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other problem, eg. uncertainty over length of stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Statutory Education

Where is/has been his/her main source of education provision?

Mainstream school	<input type="checkbox"/>	Special School	<input type="checkbox"/>	Pupil referral unit	<input type="checkbox"/>
Home	<input type="checkbox"/>	Residential	<input type="checkbox"/>	Excluded / Expelled	<input type="checkbox"/>
None	<input type="checkbox"/>	Other situation	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Special Needs Yes / No
 Statemented Yes / No

Name.....Address.....

Tel No.....

Employment, Training and Further Education

Which of the following describe his/her situation with regard to employment, training and further education?

- | | | | | | |
|--------------------------------|--------------------------|---------------------------------------|--------------------------|---------------------------------|--------------------------|
| Full-time work | <input type="checkbox"/> | Part-time work | <input type="checkbox"/> | Casual/temp. work | <input type="checkbox"/> |
| Unemployed | <input type="checkbox"/> | Pre-employment
lifeskills training | <input type="checkbox"/> | Unable to work
eg incapacity | <input type="checkbox"/> |
| College / Further
Education | <input type="checkbox"/> | Other training course | <input type="checkbox"/> | Looking after family | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | N/A | <input type="checkbox"/> | | |

Health

Are there any indications that any of the following apply to the client?

	Yes	No	Don't know
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxieties/phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details.....

Please indicate whether the following apply to the client educationally

	Yes	No	Don't know
Regularly absent for other reasons than truanting e.g parental decision, illness or other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with basic literacy/numeracy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullied at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behavioural problems

Does the client present with any significant patterns of behavioural problems (other than sexually abusive behaviours)

	Yes	No	Don't know
School refusals/non-attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspended/excluded from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delinquency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting/aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage to property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cruelty to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the client is under 21 are his/her parent(s)/carer(s) aware of this referral?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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GP Details:

Name.....

Address

.....

.....

Tel no.....

Details of Medication:					
Is the client taking any medication					
		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Medication					
Dose / day					
Prescribed for how long					

Client's History

Please include family history, details of childhood, schooling, occupational history and experience of abuse (including alleged and/or suspected.) Please continue on a separate sheet if necessary.

Offending History (including alleged and/or suspected)



REFERRAL REQUIREMENTS

Respond is unable to take a referral unless two areas of responsibility are clarified – support for the client(s) and financial responsibility for treatment. This form will be returned to you if the following page is left unsigned.

CLIENT(S) SUPPORT

This section is to be signed by the person responsible for the referral of a client to RESPOND

I agree to the following:

- My client(s) is/are supported in getting to and from RESPOND.
- A member of staff will remain on RESPOND premises for the duration of the client(s) session.
- Staff supporting the client(s) will be sensitive to the sometimes traumatic effects of psychotherapy or Risk Assessment before and after the session.
- My client(s) will be supported in arriving punctually for their session.
- Drivers accompanying the escort and client(s) will be known to the referrer, and adequate checks will have been undertaken.
- No escort is allowed to enter the consulting room unless expressly invited by the therapist.
- The escort will be over the age of 18.
- Workers' request advice and/or information should be made over the telephone and/or in writing.

.....
Signature Date

.....
Name in capitals Position

FINANCIAL RESPONSIBILITY

This section is to be signed by the officer responsible for funding the treatment. Please indicate which service funding has been agreed for.

Funding agreed for Psychotherapy / Risk Assessment

I agree to the following:

- Once a block of twelve psychotherapy or Risk Assessment sessions have been booked, no refunds can be made, unless a separate agreement has been negotiated in writing.
- Immediate notice of any problems in securing long term on-going funding will be given to RESPOND
- Invoices issued by RESPOND will be paid within 30 days of receipt.
- RESPOND may make annual increases to the costs of services.

.....
Signature Date

.....
Name in capitals Position

*** Your signature here indicates that you have read and agreed with Respond's charging policy.**

Funding Authority.....

Address.....

.....

Tel no..... Fax no..... Email.....

Risk Assessment Information

If a Risk Assessment is being requested, please tick which information you are enclosing in support of your referral.

- Psychiatric report
- Psychology report
- Pre-sentence report
- Deposition relating to the most recent offence
- Details of criminal records
- Social Service reports
- Other relevant reports

If you have any queries please contact us on 020 7383 0700
Or email to admin@respond.org.uk

Once this form has been completed and signed, please return to:

Respond
3rd Floor
24-32 Stephenson Way
London
NW1 2HD