Early Help Service

Havering
LONDON BOROUGH

Havering Children's Rights Advocacy Service Referral Form

Young Person's Information				
Name				
Current Address				
Contact number				
DOB		**Age**		
Gender				
Ethnicity				
Languages / Specific communication needs				
Disability please provide details of any disabilities				
Carers/ Parents Please provide names and contact details where possible. Please write (PR) after the name of the person with Parental Responsibility				
Professionals involved e.g. Social Worker/ Independent Reviewing Officer				
Other Key people Please provide names, type of relationship and contact details if possible				
Referral Information				
Date of referral				
Referral Source Please specify Team				
Reason for referral				
Contact Details				
Re-Referral			No	
Self-Referral			No	
Additional Information				
Please provide any further information you feel is relevant, including any pertinent risks				
Young Person's Consent				

Please email this Referral form to earlyhelp@havering.gov.uk