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).

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.

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.

DOES THE YOUNG PERSON BEING REFERRED HAVE THE REQUIRED EQUIPMENT (tablet/	**YES: ☐ NO: ☐**

smartphone/ computer; internet) AND SKILLS TO ENGAGE IN AN ONLINE PROGRAMME?	**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

Unit 14C

N5 Business Park

Moneen Road

Castlebar

Co. Mayo

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