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6VT Cairn Service

Referral Form

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| --- | --- |
| Name of referrer: |  |
| Name of organisation: |  |
| Phone number/ email address of referrer: |  |
| How did you hear about the Cairn Service? |  |
| Date of referral: |  |
| Name of Young Person: |  |
| Young Person’s DoB: |  |
| Young Person’s phone number: |  |
| Young Person’s address: |  |
| Details of crime reported / court case, if available: |  |

**Please tick off any of the options that you feel the referred Young Person would benefit from:**

**1:1 support Police interview support**

**Court (preparation) support 3rd party reporting**

**Other (please specify) Support at relevant appointments**

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| **Please outline reason for referral:** |

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| **Please outline any risks the Young Person presents to self or others that we *need* to know** (the team will follow this up with a phone call): |

**Please confirm that the Young Person has been made aware that you have made this referral:**

**Yes**

**No**

*Please return this form to the Cairn team via:* [*cairnteam@6vt.info*](mailto:cairnteam@6vt.info)

**If you would like to discuss the referral please call 07419 328598 or 0131 229 1797**