**Trafford Domestic Abuse Services - Children & Young People’s Service**

TDAS is a charity offering support to those affected by domestic abuse.

We offer a range of services that support children and young people who have witnessed or experienced domestic abuse. We provide emotional and practical support; please note we are not a counselling or therapy service.

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| **121 (5-18years)**  Child-led, tailored support around domestic abuse, emotional wellbeing, healthy relationships, and safety planning. Held in schools and community venues. | **Rspace (5-14years)**  6 week awareness and support programme focusing on domestic abuse, feelings family and safety planning. Held in community venues after school. | **Children & Family Support (5-16years)**  Supporting children and their parents/carers move forward following the impact of domestic abuse. Combination of 121 and family sessions in the family home and school. |

Our process is to initially assign every child/young person to a group for support, further support can then be discussed following the group. If you feel this is not appropriate please state within the referral.

**As a victim service it is our policy not to contact any alleged perpetrators. If both parents/carers are identified as alleged perpetrators, please provide third-party contact information eg school or social worker. Please ensure the third-party is aware of the referral.   
We would never knowingly contact or pass information on to an alleged perpetrator.**

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| Date of referral: |  |
| Referrers details  Name, job title, email, and phone number: |  |
| Has the parent/carer consented to this referral?: |  |
| Has the child/young person consented to for this referral?: |  |

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| **Other professionals involved with the child/young person, please add as appropriate** | |
| Agency | Contact |
| *School* |  |
| *Social worker* |  |
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| **Who are you referring to us?** | | | | | | |
| Child/Young Person’s name: |  | | | Child/Young Person’s DOB: |  | |
| Address: |  | | | | | |
| Contact number (if 13+): |  | | | | | |
| Child/Young Person’s school and point of contact: |  | | | | | |
| Parent/carer name and contact number: |  | | Relationship to child/young person: | | |  |
| About the child/young person you are referring to us | | | | | | |
| Disability (whether diagnosed or suspected) and any adaptions required: | | *eg ADHD – requires bigger tasks to be broken down* | | | | |
| Does the child/young person present any risk?: | | *eg weapons, drug use* | | | | |
| How does the child/young person feel they learn?: | | *eg prefers to read information, prefers to watch videos* | | | | |

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| Reasons for the referral |
| Please provide an overview to why you are referring into our service: |
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| Voice of the child – what does the child/young person want from TDAS?: |
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| Alleged perpetrator information and relationship to child/young person: |
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| Is there anything else we need to be aware of? |
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