**REFERRAL FORM  
Application for Support: Blossom Project**

The **Blossom Project** supports girls and young women aged 13-24 (or up to 25 years if they are neurodivergent), who experience multiple unmet needs and disadvantages. **One to one** and **group**, trauma informed and person centred interventions build their resilience and prevent abuse, harm and exploitation. Opportunities to lead campaigns, events and projects support to empower them and further ensure their voices are heard.

The Blossom Project offers a range of support and interventions tailored to the specific needs of young women including one to one and group/peer support. Following our initial assessment, we will determine which is most suitable for their needs. Our Blossom support journey starts by young women attending weekly small group sessions which includes craft activities, well-being sessions and informal education and awareness raising sessions.

**Please ensure this is communicated with clients and families, prior to making the referral.**

Please select likely duration of support (where known):

Short-term support  Medium-term support  Long-term support

Specific targeted piece of work to address a single need. Support ranging from 0 – 3 months.

Long term support to address complex and multiple needs. Support ranging from 6 months+.

Specific targeted piece of work to address multiple issues and needs. Support ranging from 3 to 6 months.

**Referrer Details:**

|  |
| --- |
| Name: |
| Agency: |
| Date of referral: |
| Agency address: |
| Telephone: |
| Email: |

**Young woman’s details:**

|  |  |
| --- | --- |
| Name: |  |
| D.O.B |  |
| Address: |  |
| Postcode: |  |
| Ward/area – please select from the dropdown menu | Choose an item. |
| Telephone: |  |
| Ethnic Origin: |  |
| Gender identity/pronouns: |  |
| Childcare responsibility:   * If yes number of children and ages. |  |
| Next of Kin: |  |
| Emergency Contact Number: |  |

**Please select from the list the issues that the client would like support with:**

|  |  |  |  |
| --- | --- | --- | --- |
| Emotional well-being |  | Transition support (from adolescence to adulthood) |  |
| Self-esteem/self- confidence |  | Healthy relationships education (inc online safety) |  |
| Regulating and managing emotions |  | Resilience and self-care |  |
| Social support (via group sessions) |  | Understanding risk and safety planning |  |
| Sexual harassment, violence, abuse and/or exploitation |  | Advocacy and empowerment |  |

|  |
| --- |
| **Please give reason/s for the referral and be specific about what support is being requested (please refer to the list of issues above and outline desired progress for the young woman)** |
|  |

|  |
| --- |
| **Any additional comments which may help with the referral?**  **Is there any risk information about the client/family members/their home environment that is relevant for us to know? Please include description of any risk indicators (such as offending and/or violent/aggressive behaviour) and whether these are recent or historical:** |

|  |
| --- |
| **To Be Signed By The Applicant – please note we must have the clients consent to make contact with them. Where the client is under 18 we must have consent from their parent/legal guardian:**  We may need to contact other agencies for information so we can process your application. This could include other agencies, the probation service or the social care department. The applicant agrees to this by signing the statements here.   1. **I (the applicant) hereby give my authority for any relevant agency to disclose information for the purpose of dealing with my application. I understand that this information is to be solely used in relation to my application and will not be disclosed to any other persons without my permission.** 2. **The details I have given in this application are true and correct. I understand that if I have knowingly or recklessly given any false information or withheld information about my application, it may delay the referral process.**   **Signed:**  **Name:**    **Date:**    **To Be Signed On Behalf Of The Referring Agency:**  By signing this form you are declaring all the information you have provided on it is accurate to the best of your knowledge. If inaccurate or incomplete information is provided it may result in your client losing any subsequent support we offer. This application form will be kept on the service users file, to which the service user will have access. Any information you wish to be kept confidential must be recorded as **“confidential third party information only”**  **Signed:**  **Name:**    **Agency:**  **Date:** |

***We aim to process your referral and contact you within 5 working days following receipt. Completed forms should be emailed to*** [*charlotte.gibbons@awayout.co.uk*](mailto:charlotte.gibbons@awayout.co.uk)