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| Consultations must NOT be shared without the written consent of the HSB Team |
| *This page (page 1) to be completed by referrer and returned to* *hsb@suffolk.gov.uk* |
| **Consultation Details:** |
| Date of referral: | Click or tap to enter a date. |
| Referrer: |  |
| Email: |  |
| Telephone/Mobile:  |  |
| Referrer Team: |  |
| Service Area: | Choose an item. |
| Other, please specify: |  |
| How did you hear about us: | Choose an item. |
| Other, please specify: |  |
| **FIRST NAME:** |  |
| **SURNAME:** |  |
| Address: |  |
| Date of birth, enter as dd/mm/yyyy: |  | Age: |  |
| Liquid Logic ID No: |  |
| SYJS Client ID (if known to Service): |  |
| Children’s Services Status: | Choose an item. |
| Gender: | Choose an item. |
| Other, please specify: |  |
| Ethnicity: | Choose an item. |
| Type of harmful, sexual behaviour: | Choose an item. |
| Other, please specify: |  |
| Additional diagnosis: |  |
| Mental Health / Other, please specify: |  |
| Harmful, sexual behaviour concerns, please give as much detail as possible (Please include specific details about what the HSB concerns are. e.g. name body parts, whether touching was over or under clothing, whether penetration occurred, ages of all involved, location, if describing language please use specific examples and give context etc) |  |

Once complete please return to

hsb@suffolk.gov.uk

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| Consultations must NOT be shared without the written consent of the HSB Team |
| *This page (page 2) must always be completed by professional carrying out consultation.* |
| Date of consultation: | Click or tap to enter a date. |
| Consultation facilitated by: |  |
| Role (facilitated by): |  |
| **Concerns Raised By Professional Regarding Young Person’s Sexual Behaviour:** |
| Click or tap here to enter text. |
| **Summary of Consultation:** |
| Click or tap here to enter text. |
| **Recommendations:** |
| Click or tap here to enter text. |
| **Outcome of Consultation:** | Choose an item. |