**16 & 17-Year-Old Homeless Screening Tool**

|  |  |
| --- | --- |
| Worker |  |
| Date |  |
| Time |  |

**Young Person Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name |  | | DOB &Age |  | Ethnicity |  |
| Present/Previous Address | |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Gender: | Male |  | Female |  | Trans |  |
| Sexuality |  | | | | Prefer not to say |  |

|  |  |
| --- | --- |
| Contact Telephone Number |  |

**Parent / Family Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Relationship to You | Name | DOB & Age | Contact Details: Address and Phone |
|  |  |  |  |
|  |  |  |  |
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**Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Details | Name / Address | Tel No. | Medical Conditions / Medications |
| GP |  |  |  |
| Dentist |  |  |  |
| Opticians |  |  |  |

**Do you consider yourself to have a disability (Learning / Behavioural / Cognitive)**  YES NO

|  |
| --- |
| Do you have a diagnosis? |

**Are there any professionals currently involved with the family?**  YES NO

|  |  |  |  |
| --- | --- | --- | --- |
| Agency | Contact Person | Address | Telephone Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Police Involvement / History / Pending? YOS – any offences on record / pending?**

|  |  |  |
| --- | --- | --- |
|  | | |
| Are there any issues with Anti-social behaviour? | YES / NO | Details |

**Current Situation**

|  |
| --- |
|  |

**Please comment on each of the following:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Your Health – e.g. are you eating properly? Do you have any health issues, and allergies?  Your Education – Please state NEET if not in education, training or employment  Your Emotional Well Being (current Mood)   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |   Your Relationships / Extended Family  Your Self Care Skills – e.g. cooking, cleaning, paying bills etc.  Who do you go to for support?  Have you ever self-harmed?  Have you been diagnosed with a mental health condition?  Do you take any substances, including alcohol? YES / NO  What do you take / drink? |

**YOUR VIEWS: What do you want to happen after today?**

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| --- |
|  |

**Views of Parent / Carer**

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| --- |
|  |

**Views of Others (Including Professionals)**

|  |
| --- |
|  |

**Conclusion of Screening**

|  |
| --- |
|  |

**Outcome / Initial Action Plan**

|  |  |  |
| --- | --- | --- |
| Action | By Who | Completion Time |
| Return Home |  |  |
| Support to Placement |  |  |
| Inform Housing Options Team / Integrated Front Door |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed Young Person |  | Date |  |
| Signed AEOC Worker |  | Date |  |

**Risk Screening**

|  |  |  |  |
| --- | --- | --- | --- |
| Potential Risk | Yes | No | Agreed Control Measures |
| Any Offending Behaviour |  |  |  |
| Arson |  |  |  |
| Schedule 1 Offender |  |  |  |
| Harm to Others |  |  |  |
| Self-Harm / Suicide |  |  |  |
| Self-Neglect |  |  |  |
| Substance Misuse |  |  |  |
| Mental Health |  |  |  |
| Physical Health |  |  |  |
| Prescribed Medication |  |  |  |