

Referral Form

**Child‘s Name:**

**DOB:**

**Gender:**

**Address:**

**Parent/Carer Names: Phone:**

**Email:**

**School/Education Provision:**

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| **Current Individuals/Agencies involved: Child Protection status:**  **Referral Requested by:**  **Funding to be provided by:**  **Allocated Weekly Session Hours:**  **Term time: Holidays:**  **Staff Ratio required (1:1 or 2:1):**  **Form completed by: Relationship:**  **Contact Details:**  **Date of referral:** |
| **Referral Criteria**  The young person is aged 18 years or under and meets a minimum of one of the criteria below |

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|  | Display’s significant behaviours that challenge which impact  on quality of life | Y/N |  |
|  | Is at risk of home or education breakdown (please delete as  necessary) | Y/N |  |
|  | Has accessed alternative available services but needs  continue to remain unmet | Y/N |  |
| **Service referred to (please specify)**  Care and Support Agency – Community Short Breaks Education Support Service – In Reach (Schools) Education Support Service – Out Reach (Community)  Are there preferred days for this support to be arranged for:  **If Education provision:**  Current IDP attached (If applicable): Y/N  Current School/Education Attendance Percentage: Eligible for Free School Meals: Y/N  Please also attach the following:   * Current PSP/CASP * Risk assessments * Any relevant professional reports | | | |

**Medical/Health needs** Diagnosis (if applicable): Known seizures: Asthma:

Allergies:

Medication:

Mobility:

Communication: Personal care needs: Known sensory issues:

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| **Personal Information**  Background Information:  Child’s Interests:  Child’s Dislikes:  Associated Risk Behaviours and strategies to support – *Please attach any risk assessments:*  What are the key goals for this referral: |
| **Additional Information:** |

**Please return to:** [enquiries@smoothstartsplus.co.uk](mailto:enquiries@smoothstartsplus.co.uk) [sam@smoothstartsplus.co.uk](mailto:sam@smoothstartsplus.co.uk)