

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 impacton quality of life | Y/N |  |
|  | Is at risk of home or education breakdown (please delete asnecessary) | Y/N |  |
|  | Has accessed alternative available services but needscontinue 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/NCurrent School/Education Attendance Percentage: Eligible for Free School Meals: Y/NPlease also attach the following:* Current PSP/CASP
* Risk assessments
* Any relevant professional reports
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**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 sam@smoothstartsplus.co.uk