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| **Young Person Details:**  |
| Gender:  |
| First Name: | Preferred Name   |
| Middle Names:  | Last Name  |
| Last Name:  | Date of Birth   |
| Home Address:   |
| Home Tel No:   | Home Postcode:   |
| Mobile No:   | Area: (Swale or Gravesham )   |
| Email Address:   | Last/Current School   |

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| **Emergency Contact Details:**  |  |
| Name:   | Home No:   |
| Relationship:   | Mobile No:   |

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| **Ethnic Group:**  |  |
| **White Mixed/Multiple Ethnic Group**  | **Asian/Asian British**  |
| ☐ English/Welsh/Scottish/Northern Irish/British ☐ White and Black Caribbean ☐ White and Asian  | ☐ Indian ☐ Pakistani  |
| ☐ Irish ☐ Gypsy or Irish Traveller ☐ White and Black African  | ☐ Chinese ☐ Bangladeshi  |
| ☐ Any other White background ☐ Any other Mixed/Multiple ethnic background  | ☐ Any other Asian background  |
| **Black/African/Caribbean/Black British**  | **Other Ethnic Group**  |
| ☐ African ☐ Caribbean ☐ Any other Black/African/Caribbean background  | ☐ Arab  |

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| **Health Needs:**  |  |
| Learner self-declares learning difficulty, disability or health problem ☐Yes ☐No  | ☐Asperger's syndrome  |
| ☐Disability/Health Problem ☐Profound complex disability  | ☐Mobility needs  |
| ☐Visual impairment ☐Social, emotional difficulties  | ☐Mental health difficulty  |
| ☐Hearing impairment ☐Speech, language, communication needs  | ☐Dyscalculia  |
| ☐Moderate learning difficulty ☐Temporary disability or illness (i.e., following accident or illness)  | ☐Dyslexia  |
| ☐Severe learning difficulty ☐Other medical condition (i.e., epilepsy/asthma/diabetes)  | ☐Other learning difficulty  |
| If stated ‘Other’ please specify:   |  |
| Primary LDD Need:    |

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| **Assessment of Need**  |
| What is the reason for the referral:   |
| What benefits will this programme of support bring to the young person:  |
| What are the specific barriers that need to be addressed: |
| Anything else we should be aware of: |

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| **Referrer declaration.**  |
| I confirm that to best of my knowledge the information supplied within this referral (including DOB & Home Address) is true and accurate. I confirm that the person named in this referral (the Learner) has consented to this referral being made and their information being shared.  |
| Name  |    | Position:   |    |
| Signature:  |  | Date:  |  |