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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: |  |