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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   |
| Preferred method of contact:  |

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

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

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

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| 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, including is the young person a risk to themselves or others: |

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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 young person) has consented to this referral being made and their information being shared.  |
| Name  |    | Position:   |    |
| Signature:  |  | Date:  |  |

To be returned to **davidlubendo@cxk.org.** Please make sure the referral form is password protected.