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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:** | |  |
| |  |  |  | | --- | --- | --- | | **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 |  |  | | | |
|  | |  |
| **Health Needs:** |  | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 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 | | | |  | | | |
| 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.