Young Lewisham Project Referral Form

Confidential

124 Kilmorie Road, Forest Hill, London, SE23 2SR
Tel: 0208 291 9771
Email completed form to: Info@younglewisham.org.uk

Details of Referred Young Person:	
Surname:	**Forename:**
Date of Birth:	**Male / Female:**
Home Address:	**Postcode:**
Name of School/College/Agency:	**Year Group:**

Risk and Needs of Young Person:		Medical Conditions:	
Has a disability		**ADHD / ADD**	
Has an Education, Health and Care Plan (EHCP)		**Autism Spectrum Disorders (ASD)**	
Has alcohol misuse issues		**Oppositional Defiant Disorder (ODD)**	
Has drug misuse issues		**Dyspraxia**	
Is looked-after by the Local Authority		**Epilepsy**	
Is at risk of self-harm		**Diabetes**	
Is known to the Police		**Asthma**	
Is known to Children's Services		**Visual Impairment**	
Is on a reduced school timetable		**Hearing Impairment**	
Is at risk of school exclusion		**Allergies**	
Other:		**Other:**	

Please tell us why this young person is being referred including their main difficulties or challenges: (bullet points are accepted)
To help us monitor progress please tell us the desired outcome for this young person attending the project? (bullet points are accepted)

Details of person making the referral	
Full Name:	**Job Title:**
Agency Name:	**Tel:**
Agency Address: **Postcode:**	**Email:**
Signed:	**Date:**

Parent/Carer Information:	
Parent/Carer Full Name:	**Relationship:**
In Case of Emergency –	**Mobile:** **Tel:**
Does the young person have parental permission to attend the Project? **Yes / No**	

Please note that unless it is agreed otherwise at the time of referring, the agency completing this Referral Form will be invoiced for the services provided, where appropriate.