

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:**  |  |

|  |
| --- |
| **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**  |