

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](mailto:Info@younglewisham.org.uk)

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

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| **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:** |  |

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

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