**Employability & Wellbeing Team**

**Young Person Referral Form**

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| **Referrer Details**  |
| Organisation Name  | Contact Name: |
| Address: | Office Number: |
| Mobile: |
| E mail address: |
| Date of referral: |
| Does the young person know you are referring them? | Yes  | No  |
| Have you asked permission from the young person to share their personal information? | Yes  | No |
| Young Person Details  |
| Name: | D.O.B |
| Address: | Home Tel No: |
| Mobile: | E mail address  |
| N.I number  |
| Which service are you referring to?  |
| Activity Agreement  | The Gate  | Old School Café Volunteering  | Cooking Group  |
| Girls Health & Wellbeing  | Power Up Programme  |  |  |

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| **BARRIERS TO EMPLOYMENT/EDUCATION/TRAINING**Please tick the appropriate box/es |
| Additional learning needs (Dyslexia/ADHD) |  | Drug/alcohol issues |  | Emotional/behavioural difficulty |  |
| English as a second language |  | Homeless |  | Lack of confidence |  |
| Literacy/numeracy |  | Looked After/After Care |  | Low Communication/Interpersonal Skills |  |
| Low Vocational Skills/Qualifications |  | MCMC |  | Mental Health |  |
| Motivational issues |  | Physical Health/Disability |  | Young Carer |  |
| Young Parent |  | Young Offender |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| Does the young person have a long term disability, health problem or any learning difficulties? **Yes** [ ]  - **Please tick all that apply below** **No** [ ]  |
| If yes, are you registered disabled? **Yes** [ ]  **No** |
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| **DISABILITY TYPE**[ ]  Visual impairment[ ]  Hearing impairment[ ]  Disability affecting mobility [ ]  Other physical disability[ ]  Other medical condition (Eg. Epilepsy, Asthma, Diabetes)[ ]  Emotional/behavioural difficulties [ ]  Mental health difficulty[ ]  Temporary disability after illness (Eg. Post-viral, accident)[ ]  Profound complex disabilities[ ]  Aspergers Syndrome[ ]  Multiple disabilities[ ]  Other disability[ ]  Not known/information not provided | **LEARNING DIFFICULTY**[ ]  Moderate learning difficulty[ ]  Severe learning difficulty[ ]  Dyslexia[ ]  Dyscalculia[ ]  Other specific learning difficulty[ ]  Autism spectrum disorder[ ]  Multiple learning difficulties[ ]  Other LLDD[ ]  Not known/Not provided |

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**Please provide a brief outline of the reason for referral**

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**Is the young person receiving any other support or working with any other agencies?**

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