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

**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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