**Employability & Wellbeing Service**

**Young Person Referral Form**

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| **REFERRER DETAILS** | | | | |
| Organisation Name:  (if applicable) | | Contact Name: | | |
| Address: | | Office Number: | | |
| Mobile: | | |
| Email address: | | | | |
| Date of referral: | | | | |
| Relationship to young person: | | | | |
| 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: | | Email address: | | |
| N.I number (if known): | | | | |
| Which service are you referring to? (feel free to contact us if uncertain) | | | | |
| NOLB Activity Agreement | The Gate - One-to-One Support | Young Parents Support | | Boys Group |
| The A Teens | Give it a Go | Wellbeing Group | | Power Up Programme (On hold) |

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| **WELLBEING CONCERNS AND BARRIERS TO EMPLOYMENT/EDUCATION/TRAINING**  Please tick the appropriate box/es | | | | | |
| Additional Learning Needs (Dyslexia/ADHD) |  | Drug/Alcohol/Gambling  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 |  |
| Social Isolation |  | Low Self-esteem |  | Lack of Exercise/Physical Activity |  |
| 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 they 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  Other (please specify): | **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  Other (please specify): | |

**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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