**Employability & Wellbeing Service**

**Young Person Referral Form**

**N.B. We ask that this form be completed alongside the young person you are referring so you can ensure they are giving consent to their details being shared with us.**

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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: |
| **YOUNG PERSON DETAILS** |
| Name: | D.O.B: |
| Address: | Home Tel No: |
| Mobile: | Email address: |
| N.I number (if known): |
| Which service below are you referring to? (Mark an X beside or highlight) |
| The Gate - One-to-One SupportNetworks - Young Parents SupportHospitality Training |

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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 |  | Lack of Childcare |  | Mental Health |  |
| Motivational Issues |  | Physical Health/Disability (see below) |  | 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 that we should be aware of? **Yes** [ ]  - **Please tick all that apply below** **No** [ ]  |
| If yes, are they 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 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 providedOther (please specify): |

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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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