Doc Code: CS/F30
Issue No: 11
Issue Date: May 2018

Community Inclusion Referral Form

Referral Agent Details	
Name;	
Address;	
Job Title;	Trust Area:
Telephone No;	E Mail Address;

Service Requested (Please Tick)	
Outlook	
Inreach	
Family Focus (WHSCT – Northern)	
Family Support (WHSCT – Northern)	
Transitions	
Youth Matters	

Child/Young Person's Details
Name:
Address:
D.O.B:
Parent/Carer:
Contact Number/s:
Contact Email Address:
Siblings:

Child/Young Person's Disability Information	
Diagnosis:	
Physical/Mobility:	
Behaviour:	
Communication:	

Medical Needs:	

School Profile

Name of School:

Academic Year:

Social Services Involvement

Family & Childcare ☐

Contact Details:

Children/Adult Disability Team ☐

Contact Details:

Child Protection Issues:

Yes ☐ No ☐

Other Relevant Professionals Involved

Community Children's Nurse ☐

Contact Details:

Behavioural Intervention Team ☐

Contact Details:

Physiotherapy/Speech & Language/Occupational Therapy ☐

Contact Details:

Referral Agent Signature: ……
(Can also be electronic)

Date: ……..

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Complete for ASD referrals only

Please complete the support needs section below, giving details as appropriate

	Support Needs	Level of Support Needed (1- high, 2- medium, 3- low)	Any Associated Risk?
Communication/Social Skills (e.g, verbal/non-verbal, relationships with peers/adults)			
Emotional/Behavioural (e.g challenging, angry/aggressive, anxious, inappropriate, repetitive/rigid, withdrawal (include their special interest)			
Sensory Sensitivities (e.g noise, light, crowds, touch, smell, food, pain tolerance)			
Executive Function (e.g structure, planning, organising, decision making)			
Mental Health (e.g diagnoses, addictions, self harm, suicide attempts, triggers)			

Physical/Mobility (e.g Dyspraxia, co-ordination, balance difficulties)			
Medical (e.g Epilepsy, Asthma, allergies)			
Personal Safety/ Vulnerability			
Other diagnoses/ Identifiable Risks			

Any Additional Information:

Referral Agents Summary of Assessment attached: YES / NO

Referral Agent Signature: _____ Date: _____