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| New Referral Form

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| **YOUNG PERSON’S DETAILS** |
| Full Name: |  |
| Age & Date of Birth: |  |
| Home Address: |  |
| Parent / Carer Full Name: |  |
| Email Address: |  |
| Phone Number: |  |

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| **SUPPORT NEEDS:** |
| What service(s) would you like to access? | Saturday Clubs |  |
| Holiday Clubs |  |
| Do you have an EHCP?  |  |
| Do you have a Support Plan?  |  |
| **Care Needs**:Please list any diagnosis, medical conditions and care needs. e.g. Epilepsy, PEG, wheelchair user, Allergies, Autism, learning disabilities, behavioral needs. |  |
| **My Mobility:** |  |
| **My Communication:**  |  |
| **Activities**:Please list your likes and dislikes  |  |

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| **SERVICE FUNDING:** |
| How will the placement be funded? (If Direct Payment, please indicate whether it is used for PA’s, Activities or care.) | Delete as appropriate.* Self-funded
* Direct Payment
 |
| Which local authority do you come under? |  |

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