Preparing for Adulthood REFERRAL FORM

Please complete this form electronically and fill in as much detail as possible. Any sections with an * and in **BOLD** MUST be completed for the referral to be accepted. Any extra documentation with the referral is very helpful and gratefully received.

Referral Information	Date of referral	
	Name of referrer and job title	
	Allocated worker	
	Team manager	
	Contact telephone	
	Contact email	
	***Has permission to share information been given? Y/N Please include permission to share information form**	
Young persons details	***Name of young person**	
	***DOB**	
	***Ethnicity**	
	BCP Reference No	
	***Permanent address**	
	***Telephone number**	
	Email Address	
	***Next of Kin/Nearest relative**	
	***What outcomes does the young person expect to achieve as a result of this referral?**	
Diagnosis (This needs to include supporting documentation)	***Diagnosed Disability**	
	Primary need e.g. learning disability, ASD, sight & hearing, physical etc.	

	***Are there any significant risk that others need to be made aware of?**			
Professionals Involved	***GP name and address**			
	***School**			
	***Other involved Professionals e.g. Consultant, Nurse Occupational Therapist etc**			
Current Placement/ Care Package **This information is very important from social care referrers**	Placement, location			
		Y/N	Cost PW	Cost PA
	Residential (please state 38 or 52 week)			
	Foster Care			
	Shared Care			
	Short breaks/respite			
	Direct Payment			
	Day care			
	Transport			
	Education Funding			
	Health Funding			
	Any other			
What does the young person want to achieve from this referral?				

Please send the completed referral form, along with any supporting documents to – asc.contactcentre@bcpcouncil.gov.uk 01202 123 654