Referral Form 

**Email completed form to:** **provision@yourbeautyschool.co.uk**

Please complete this form with as much information as possible.

| **It is important to NOT leave any spaces blank, please mark N/A where not applicable.****Please attach any relevant documents such as risk assessments, IHP and EHCP.****Referral will not be accepted if it is not completed.** |
| --- |
| **Referrer’s Details** |
| **Name**  |  |
| **School or Organisation**  |  |
| **Position** |  |
| **Contact number** |  |
| **Email address** |  |

| **Young Person’s Details** |
| --- |
| **Name:**  |  |
| **Date of birth:** (dd/mm/yyyy) |  |
| **Age:** |  |
| **Unique Pupil Number (UPN):** |  |
| **Registered school name & address:** |  |
| **Previous School details:** |  |
| **Gender:** |  |
| **Ethnicity:**  |  |
| **How long has the young person been out of education?** |  |
| **Does the young person have EHCP?** | ☐ Yes ☐ No |
| **Is the young person a Looked After Child?** | ☐ Yes ☐ No |
| **Parent/Carer Details** |
| **Name:** |  |
| **Relationship:** |  |
| **Address:** |  |
| **Contact number:** |  |
| **Email**  |  |

| **Emergency contact details** |
| --- |
| **Name**  |  |
| **Relationship to learner** |  |
| **Address** |  |
| **Contact number** |  |
| **Work contact** |  |
| **Email address** |  |

| **Is the learner under the care of Social Services?** | ☐ Yes | ☐ No |
| --- | --- | --- |
| **Name of social worker** |  |
| **Address**  |  |
| **Contact number** |  |
| **Email address** |  |

| **Medical information** |
| --- |
| **Please state any medical conditions that the learner has.** |
|  |
| **Please list any medication that the learner takes and any side effects that they experience.** |
|  |

| **Does the young person have a SEN?** | ☐ Yes | ☐ No |
| --- | --- | --- |
| **If yes, please provide details and attach relevant documents:** |  |
| **What treatment has been prescribed?** |  |

| **Does the young person have a mental health condition?** | ☐ Yes | ☐ No |
| --- | --- | --- |
| **If yes, please provide details of diagnosis:** |  |
| **What treatment has been prescribed?** |  |

| **Please select the following that applies:** |
| --- |
| ☐ Traveller/Gypsy☐ Teenage Parent☐ Behaviour management issues☐ In public care☐ Bullying behaviour☐ Expresses racist/sexist/homophobic views☐ Child Protection issues☐ Victim of bullying | ☐ Has a disability☐ Caring responsibilities☐ Young offender☐ Literacy support needs☐ Refugee/Asylum seeker☐ Drug/substance involvement☐ History of truancy☐ History of violence |
| **Details:** |
|  |

| **What is the reason for this referral?** |
| --- |
|  |
| **Start Date** (dd/mm/yyyy)**:** |
|  |
| **Number of days per week required** |
|  |
| **Required length of placement for learner:** |
|  |
| **Are there any additional support needs? (i.e. Educational or emotional) Please state:** |
|  |
| **What does the learner hope to achieve from this placement?** |
|  |
| **Please provide any additional information that you feel will be relevant.** |
|  |

| **CheckList: I confirm I have uploaded the following most recent supporting documents:** |
| --- |
| **Education Health Plan (EHCP)** Yes ☐ N/A ☐I**ndividual Health Plan**Yes ☐ N/A ☐**Risk Assessment**Yes ☐ N/A ☐**Individual Learning Plan**Yes ☐ N/A ☐**Other**Yes ☐ N/A ☐ |

| **Date (dd/mm/yyy):** |  |
| --- | --- |