

REFERRAL FORM

Please fill out every field to the best of your knowledge.

* Required

Which SCG provision are you referring to?*

SC Surrey

SC Outreach

SC Mini

Creative Hair & Lashes

If you selected **SC Mini**, please specify the location (Croydon / Sunbury / NEAT Epsom):

YOUNG PERSON'S INFORMATION

Full Name*			
Preferred Name			
Age*		Date of Birth*	
Address*			
Ethnicity*			
Religion			
Gender*			
School Year*			
Current School / Placement / Provision*			
How long have they been at their current school? (If less than 1 year, please provide further information)			
Current Attendance (Please include latest attendance certificate in an email, along with the completed referral form)			



CURRENT LEARNING LEVELS

(If you are filling out a printed version of the referral form, please indicate KS1 & KS2 learning levels as: *Working significantly below / towards / at / above expected level.*)

Pupils in KS1 & KS2:

Select current Literacy Learning Level

Select current Numeracy Learning Level

Students in KS3 & KS4:

Please provide their current English Grade

Please provide their target English Grade (1-9)

Please provide their current Maths Grade

Please provide their target Maths Grade (1-9)

If the Young Person is not working to age-related expectations, please outline their current learning levels (including any school-specific assessment):

Literacy / English Level

Numeracy / Maths Level



Which of the following documentation have you provided to support this referral?

Tick all that apply.

EHCP

Last Academic Report

Behaviour Report

Last 2 Years Attendance Certificate

EP Report

Does the Young Person have any allergies or medical conditions we should be aware of?*

Please list any identified health needs, **including** current medication being taken.

Yes

No

Does the Young Person fall into any of these categories? Tick all that apply.

CLA

CP

CiN

Early Help

FSM

Young Carer

Does the Young Person currently have a case worker/social worker?*

Select Yes or No. If yes, please provide their name and contact details below.

Yes

No

Case Worker / Social Worker's Details

Full Name	
Phone	
Email	



Reason for Referral:*

Please outline in detail why the young person is seeking our support (e.g., interim return to mainstream, waiting on specialist setting, or to run alongside another programme) and what they are hoping to gain from the provision.

Does the Young Person have an EHCP?*

If yes, please include this in an email, along with the completed referral form.

Yes

No

Does the Young Person have any SEN / SEMH / Learning Difficulties?*

If yes, please tick all that apply below.

Yes

No

Needs	<input checked="" type="checkbox"/>
Communication / Understanding	<input type="checkbox"/>
Emotional Dysregulation	<input type="checkbox"/>
Speech & Language	<input type="checkbox"/>
Care-Seeking Behaviour	<input type="checkbox"/>
Autism / ADHD	<input type="checkbox"/>
Toileting Issues	<input type="checkbox"/>
Separation Anxiety	<input type="checkbox"/>
Developmental Delays	<input type="checkbox"/>

Needs	<input checked="" type="checkbox"/>
Experience of Trauma	<input type="checkbox"/>
Experience of Loss / Bereavement	<input type="checkbox"/>
Parental Mental Health	<input type="checkbox"/>
Parental Physical Health	<input type="checkbox"/>
Sibling Mental Health	<input type="checkbox"/>
Sibling Physical Health	<input type="checkbox"/>
Experience of Abuse	<input type="checkbox"/>



AREAS OF CONCERN*	<input checked="" type="checkbox"/>	PLEASE GIVE DETAILS
Physical or aggressive behaviour towards peers or family members		
Physical or aggressive behaviour towards staff		
Gang affiliation		
Substance misuse (Drugs or Alcohol)		
Bullying others		
Being bullied		
Deliberate self harm		
Inappropriate sexual behaviour		
Exhibiting a fear of being alone		
Absconding		
Anti-social behaviour		
Risk of exploitation (sexual, financial, emotional)		

Family History:*

Please tick all risk factors experienced by the Young Person.

Risk Factors	<input checked="" type="checkbox"/>
Domestic Violence	
Neglect	
Experience of Trauma	
Experience of Abuse	
Experience of Loss / Bereavement	

Risk Factors	<input checked="" type="checkbox"/>
Parental Mental Health	
Parental Physical Health	
Sibling Mental Health	
Sibling Physical Health	
Abandonment	



Does the Young Person have regular Risk Assessments?*

Yes

No

SAFEGUARDING CONCERNS*

Please share information regarding any safeguarding concerns (e.g. neglect, abuse, exploitation, mental health risk), along with dates, current risk level, and external agency involvement.



Please give a brief outline of the Young Person’s current living circumstances, relationships with parents/guardians and any other information relating to their home life which may be important i.e. traumas, bereavements, or sensitive info etc.

Please give details of the Young Person’s achievements, strengths, interests and hobbies:

Strengths	
Interests & Hobbies	
Dislikes	



Any other relevant information:

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1. PARENT / GUARDIAN CONTACT DETAILS*

Full Name	
Relationship to Young Person	
Phone Number	
Email	
Address	

2. PARENT / GUARDIAN CONTACT DETAILS (Optional)

Full Name	
Relationship to Young Person	
Phone Number	
Email	
Address (If different)	

EMERGENCY CONTACT*

Full Name	
Relationship to Young Person	
Phone Number	



REFERRER'S INFORMATION*

Referrer's Full Name	
Referrer's Role	
Phone Number	
Email	
School / Service	

DECLARATION*

Any information relating to racial or ethnic origin, physical or mental health and criminal convictions constitutes sensitive data as defined by section 2 of the Data Protection Act 1998. I consent to the information given by me being used, in accordance with the principles of the above-mentioned Data Protection Act, for the purpose of processing this application for a placement with the Sporting Chances Group. The above information is true and is accurate to the best of my knowledge.

Referrer's Signature (can be typed)		Date	
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Please send your completed referral form together with any relevant reports to referrals@sportingchances.org.

If you require any further information, please call us on **07791 262122**.



PLACEMENT FUNDING INFORMATION

David Johnson
Sporting Chances Group

Edge Youth Centre
34 Rowden Road
KT19 9PW

 07791 262122

YOUNG PERSON'S INFORMATION

Full Name*		Date of Birth*	
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How many days per week will your young person be attending?*

Select the preferred days below (Please note this not relevant for SC Mini Croydon applications):*

Monday

Tuesday

Wednesday

Thursday

Friday

What is the expected end date of this placement?*

*Please note, all placements will be subject to a 1 term commitment and every 2 weeks thereafter.

Who will be funding this placement?*

School

Local Authority

Is a Purchase Order required?*

Yes

No

INVOICE RECIPIENT DETAILS*

Full Name			
Role			
Email		Phone	

If you have any finance questions regarding the placement information above, please contact finance@sportingchances.org.