|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of child or Young Person | |  | | | | DOB |  |
| Please delete or circle to indicate which service you are referring for: | | | | | | **AGE** |  |
| Elysian Education Provision - This may involve an additional enrolment form (admission process)  Education Other Than At School Placement (EOTAS) If so – how many sessions/days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapeutic Placement (Therapeutic work experience) If so – how many sessions/days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapy (which are usually weekly 50min sessions, this also includes (OT) Occupational Therapy)  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please include EHCP and relevant assessments in all referrals | | | | | | | |
| Name of referrer |  | | Role/Relationship to Child/Young Person | |  | | |
| Email |  | | Phone |  | | Mobile |  |
| Address |  | | | | | | |
|  | | | | | | | |
| Parent/Carer name(s) |  | Address |  | | | | |
| Email |  | Phone |  | | | Mobile |  |
| Parent/Carer name(s) |  | Address |  | | |  |  |
| Email |  | Phone |  | | | Mobile |  |
| GP Details |  | | | | | Phone |  |
| ABOUT THE CHILD OR YOUNG PERSON  Please outline the reasons for referral to Elysian. We would like to hear about the background, the positives, the likes and dislikes, the particular needs and any current challenges, and what the child or young person is currently accessing. | | | | | | | |
|  | | | | | | | |
| If you were to outline the outcomes you, the family and the child/young person are hoping for in three separate goals for them at Elysian, what would they be? | | 1.)  2.)  3.) | | | | | |
| Please can you outline any  known risks | |  | | | | | |
| Has the child or young person  got a social worker?  If so, please give details  (details for social worker  and current involvement/  intervention, e.g. CIN/CP etc) | |  | | | | | |
| Please can you outline any  medical needs, including  current medication, allergies  or significant medical history  we need to be aware of | |  | | | | | |
| Is there anything else that  we should know? | |  | | | | | |
| Please complete and send to [refer@elysianuk.org](mailto:refer@elysianuk.org) If you have any queries or questions you can also call the office on 01483 898517. | | | | | | | |