|  |  |  |  |
| --- | --- | --- | --- |
| Name of Young Person: |  | DOB |  |
| Please delete or highlight to indicate which service you are referring for: | **AGE** |  |
| Elysian Education Provision (usually full time or working towards full time) YES / NO Education Other Than At School Placement (EOTAS) (1-4 days per week) YES / NOTherapeutic Work Experience (TWE) (2 hour sessions 1-4 times per week) YES / NOPlease attach EHCP and relevant assessments in all referrals to inform our understanding of the needs of your young person. |
| Name of referrer |  | Role/Relationship to 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 PERSONPlease 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, such as how the child/young person currently regulates 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 anyknown risks |  |
| What professionals or services is your young person working with, for example Children’s Services, CAMHSIf so, please provide details(contact details and current involvement/intervention, e.g. CIN/CP etc) |  |
| Please can you outline any medical needs, includingcurrent medication, allergiesor significant medical historywe need to be aware of |  |
| Is there anything else thatwe should know? |  |
| Please send any queries and/or completed form to refer@elysianuk.org |