**Aiming Higher Referral form**

**Please ensure ALL sections are completed thoroughly. In the case the form is not completed with enough information the referral may be returned and this would delay the family being offered support from our service. Please return completed form to** [**referrals@aiminghighercharity.org.uk**](mailto:referrals@aiminghighercharity.org.uk?subject=Referral%20Form)

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| **OFFICE USE ONLY** | ***Your data will be kept in accordance with the General Data Protection Regulation (GDPR) (EU) 2016/679. This will be held securely and confidentially. Aiming Higher is registered with the Information Commissioners Office (Reg No ZA187596)*** |
| Date Referral Received |

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| **Parent/Carer Details 1** | | Relationship to child with disability: | | |
| Title: | First Name: | | | Surname: |
| Address & Postcode: | | | | |
| Gender: | | | Date of Birth: | |
| GP Surgery: | | | Ethnicity: | |
| Contact Number: | | | Email: | |
| Do you have a disability or any form of ill health (including mental health)? | | | | |
| Marital status: | | | Employment status: | |

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| **Parent/Carer Details 2** | | Relationship to child with disability: | | |
| Title: | First Name: | | | Surname: |
| Address & Postcode: | | | | |
| Gender: | | | Date of Birth: | |
| GP Surgery: | | | Ethnicity: | |
| Contact Number: | | | Email: | |
| Do you have a disability or any form of ill health (including mental health)? | | | | |
| Marital status: | | | Employment status: | |

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| **Details of Child 1 with Disability** | | |
| **1)** Name: | Date of Birth: | |
| School: | Ethnicity: | Gender: |
| GP Surgery: | EHC Plan? | |
| Disability/Additional Need? | | |

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| **Details of Child 2 with Disability** |  | |
| **2)** Name: | Date of Birth: | |
| School: | Ethnicity: | Gender: |
| GP Surgery: | EHC Plan? | |
| Disability/Additional Need? | | |

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| **Additional Children/Siblings (Aiming Higher support the whole family and include siblings wherever**  **possible.)** | | |
| **Sibling Details:** | | |
| Name: | Date of Birth: / / | |
| School: | Ethnicity: | Gender: |

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| Name: | Date of Birth: / / | |
| School: | Ethnicity: | Gender: |

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| Name: | Date of Birth: / / | |
| School | Ethnicity: | Gender: |

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| **Are any of the following in place? Parental consent must be in place to attach these documents to this referral.** | **Yes** | **No** | **Attached** |
| Early Help Assessment |  |  |  |
| Child in Need Plan |  |  |  |
| Child Protection Plan |  |  |  |

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| Are there any known risks we need to be aware of? (for example: volatile behaviour in the home, dogs, disputes with neighbours, drug/alcohol use) |

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| **Details of all Current Support/Services Involved with the family (eg. Doctor/Specialist, Health visitor, CAMHS, SENCO)** | | |
| Organisation | Contact Name | Contact Number |
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| **Services available at Aiming Higher:**  **Please tick all services you are interested in accessing.**   * Once a month Family Activity * Counselling (Over 18s and not currently receiving mental health support elsewhere) * 0-5 Years Groups (Pre-schoolers, term time only) * One to One Family Support Worker * Parent/Carer Coffee and Chat/workshops * A-Team (youth group for YP aged 11–25-years with a diagnosis of ASD with a Blackpool postcode)   **If you require a family support worker, what support do you and your family require?**  **Please bullet point any actions or support needs identified that requires Aiming Higher intervention:**   * **For example – child in need of additional support at school, advice on EHCP process** * **For example – Family have financial/housing issues due to child’s needs, advice on budget/benefits/housing applications.** * **For example – Parent struggling to manage child’s needs/behaviour, advice on behaviour management/counselling.** |

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| **Referrer Details** | | |
| Where did you hear about Aiming Higher? |  | |
| Is this a Self-referral? | Yes | No |
| Name: | Organisation (if applicable): | |
| Job Title (if applicable): | Contact No: | |
| Signature: | Referral Date: | |

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| **WHEN THE PARENT/CARER IS ALLOCATED A FAMILY SUPPORT WORKER, THE SUPPORT WORKER WILL**  **MAKE 3 ATTEMPTS TO COMMUNICATE WITH THE PARENT/CARER. IF THEY DO NOT HEAR BACK FROM**  **THE PARENT/CARER WITHIN 2 WEEKS OF THE FIRST COMMUNICATION ATTEMPT, THE REFERRAL WILL**  **BE CLOSED. PLEASE TICK THIS BOX TO CONFIRM THIS HAS BEEN UNDERSTOOD.** | | |
| **Consent Details (all consent may be withdrawn at any time in line with UK data protection laws)** | | |
| Has the parent/carer consented to this referral? | Yes | No |
| Has the parent/carer consented to Aiming Higher making contact directly with them by phone? | Yes | No |
| Has the parent/carer consented to Aiming Higher making contact directly with them by email? | Yes | No |
| Has the parent/carer consented to Aiming Higher adding them to their email mailing list?  (to receive details of events, activities and their quarterly newsletter. This mailing list is never  shared or sold to other parties) | Yes | No |
| Has the parent/carer consented to the sharing of any documents  attached to this form? | Yes | No |