Early Intervention Referral

PART A – Referrer consent (if this is a self-referral, please complete part B,C & D only)	
Date of referral	
Name of referrer	
Referral organisation & department/service	
Telephone number (Landline)	
Telephone number (Mobile)	
Email address	
Relationship with client/how long have you been working with the client? *(If applicable)*	
Has consent been given for this referral?	Verbal ☐ Written ☐
I confirm that I have spoken to this individual, have discussed this referral, and they have given me consent to pass their details onto the service.	

PART B – Referral information		
Parent / Carer Full Name		
Parental responsibility		
Name of child		
Date of Birth		
Name of Nursery or School		
Name of GP surgery and NHS number		
Names of siblings (if applicable)		
Address		
Telephone number (Landline)		
Telephone number (Mobile)		
Preferred method of contact	Email ☐ Mobile No. ☐ Landline No. ☐ Letter ☐	
Preferred language to receive the service? Written and verbal	☐ English correspondence ☐ English verbal Other:……………………..	☐ Welsh correspondence ☐ Welsh verbal
Reason for referral (please tick all that apply)	☐ Mental health and wellbeing ☐ Social isolation ☐ General health and fitness ☐ Housing / environment ☐ Long Term Health Condition ☐ Debt / Finance ☐ Practical help at home ☐ Employment / Learning / training ☐ Family relationships / parenting support ☐ Aged 8-18 & due to their behaviour is at risk of getting into trouble with the police	☐ Other (please state)

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What are the worries and concerns of the person/family you are referring?

What do you hope to achieve for this person/family as a result of this request for help?

Any medical/mobility/disability/developmental issues (please state and attach any relevant assessments)	
Do you know of any other services (statutory or voluntary) supporting the individual currently? (please state)	
Are there any identified risks (to self or others) we should be aware of? (please state)	

PART C – Consent

I understand that in order for me to get the most appropriate help available, this information may be shared with other organisations who would be able to provide the services I may need. I understand this information will be treated as confidential (although it may be used in anonymous form for statistical or research purposes).
I understand that I have the right to change my mind about being referred to the service and to withdraw consent.
I also understand that I have a right of access to my information. I give permission for my referrer to be kept informed of my progress.
This information will not be shared with any other organisation unless you have consented, or unless we are required by law to share it, or if you or any other person will come to some harm if we do not share it.

Consent granted (please tick) ☐ **Date:** ___________________________

Part D – Instructions for referrer

Please send completed form: Early Intervention
Address: 9 Market Street, Aberystwyth, Ceredigion, SY23 1DL
Email: timplantanabl@ceredigion.gov.uk
For all enquiries call: 01970 627016

CRM enquiry number (For office use only)	

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CEREDIGION
County Council