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| Section 1: Information about the individual being referred |

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| Title: | Please select | First Name(s): | Click here to enter text. | | Surname: | | Click here to enter text. |
| Address:  Post Code | | Click here to enter text.  Click here to enter text. | | | | | |
| Gender: | | Click here to enter text. | | Date of Birth: | | Click here to enter a date. | |
| Landline: | | Click here to enter text. | | Mobile Number: | | Click here to enter text. | |
| Email address: | | Click here to enter text. | | ERICA Number: | | Click here to enter text. | |

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| What service do you wish to access?  Employment Support  Volunteering Support |

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| Has the individual consented to this referral?  Please select |

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| Section 2: Current Support  *Please indicate other professionals currently supporting the individual* | | | |
| Name: | Click here to enter text. | | |
| Role & Organisation: | Click here to enter text. | | |
| Telephone Number: | Click here to enter text. | Email address: | Click here to enter text. |
|  | | | |
| Name: | Click here to enter text. | | |
| Role & Organisation: | Click here to enter text. | | |
| Telephone Number: | Click here to enter text. | Email address: | Click here to enter text. |

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| Section 3: Health Details  *Please provide any relevant medical information that needs to be taken into consideration when planning support, for example. Visual/hearing impairment, mental health issues, mobility support needs, learning disability, epilepsy, behavioural or issues, diabetes, dysphasia , cerebral palsy , autism, phobias and/or allergies* |
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| Section 4: Communication | |
| If English Is not the first language, will the individual need extra language support? | Please select |
| The service is committed to meeting each individual’s needs.  Please provide any other information about the individuals cultural background that will help us get this right | |
|  | |
| What is the individuals preferred method of communication?  Click here to enter text. | |
| Has the individual any communication difficulties? Please select  If yes, please provide details of communication difficulty and methods to support communication  Click here to enter text. | |

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| Section 5: Care Plan  *Please insert recent care plan and or Education Health Care Plan* | |
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| Section 6: Travel Experience | |
| Can the individual travel on their own? | Please select |
| If yes, how do you travel? | |
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| If no, what support is needed? | |
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| Section 7: Reason for referral |
| What are the expected outcomes of this referral? |
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| Has the individual consented to this referral? |
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| Please provide further information that is relevant to this referral |
| Have any risks been identified with the referral that impact on lone workers visiting the family and/or property. |
| Click here to enter text. |

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| Section 8: Referring Community Worker |
| **Name** |
| Click here to enter text. |
| **Contact details** |
| Email  Click here to enter text.    Telephone  Click here to enter text.  Signature  Click here to enter text.  Date  Click here to enter a date. |

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| Section 9: Protecting your information |

The information contained in this form will be used by the service for the purposes of finding the right support. BMBC will ask for your permission to share the information with other training providers/voluntary organisations or employees

**At BMBC we are committed to protecting and respecting your privacy. Our website tells you what you can expect when we collect and process your information. This can be found at** [**www.barnsley.gov.uk/privacy**](http://www.barnsley.gov.uk/privacy)

Please return the completed form to [supportedemployment@barnsley.gov.uk](mailto:supportedemployment@barnsley.gov.uk)

**FOR OFFICE USE ONLY**

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| Section 10: Outcome of Referral |
| Has this referral met the eligibility criteria? |
| Please select |
| Explain below reasons for not accepting this referral |
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| Able Officer Name……………………………………………………………………………….  Able Officer Signature……………………………………………………………………………  Date referral returned……………………………………………………………………………. |
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