**Smiles for Miles Base Project - Referral Form for External Agencies**

Upon receiving your referral, the project coordinator and/or a Service Provider will contact the referrer to support the accessing of your client/ child to the opportunities they have identified an interest in.

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| **How did you find out about the Smiles for Miles Base Project?**  |
| Click here to enter text. |

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| **REFERRER DETAILS**  |
| **First Name**  | Click here to enter text. | **Surname** | Click here to enter text. |
| **Referral Agency**  | Click here to enter text. | **Role** | Click here to enter text. |
| **Office No.** | Click here to enter text. | **Mobile No.** | Click here to enter text. |
| **Email**  | Click here to enter text. |

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| **PARTICIPANT DETAILS**  |
| **First Name**  | Click here to enter text. | **Surname** | Click here to enter text. |
| **Age**  | Click here to enter text. | **First three digits of post code**  |  |
| **Sexuality** | [ ]  Heterosexual [ ]  Bi-sexual [ ]  Lesbian/Gay [ ]  Prefer not to say  |
| **Gender Identity** | [ ]  Male [ ]  Female [ ]  non-binary [ ]  Transgender [ ]  Intersex [ ]  Other |
| **Ethnicity**  |

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| **White British** | **White Irish** | **Gypsy/ Traveller** | **White (Other)** | **Black African** | **Black Caribbean** | **Black (Other)** |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Indian** | **Pakistani** | **Bangladeshi** | **Chinese** | **Yemeni** | **Asian (Other)** | **Romanian** |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Slovakian** | **Turkish** | **Arab** | **Iranian** | **Mixed Heritage** | **Other Heritage** | **Prefer not to say** |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **SEND?** | [ ]  Yes [ ]  No |
| **Contact No.**  | **Home**: Click here to enter text. **/ Mobile:** Click here to enter text. |
| **Email** | Click here to enter text. |
| So that we can make your involvement in the Smiles for Miles Base Project a positive experience, please tell us about any relevant requirements, injuries, illnesses, medications or needs you have  |
| Click here to enter text. |
| **PARENT/ CARER** (The person signing this form)  |
| **Full Name**  | Click here to enter text. |
| **Relationship to Young Person** | Click here to enter text. |
| **Legal Guardian?**  | [ ]  Yes [ ]  No |
| **Contact Number** | Click here to enter text. |
| **Email** | Click here to enter text. |
| **2ND EMERGENCY CONTACT** (Optional) |
| **Full Name**  | Click here to enter text. |
| **Relationship to Participant**  | Click here to enter text. |
| **Contact Number**  | Click here to enter text. |
| **REFERRAL DETAILS**  |
| **Which of the following activities / services would the participant like to get involved in?**  |
| **Open access youth clubs:** *you do not need a referral form for open access provision. If you need some advice on which base would be most suitable, you can use this referral form to discuss.* [ ]  All/ Any – more information required[ ]  Fitness sessions: NY Stadium [ ]  Football/ activities: Parkgate [ ]  Youth Club: Dinnington [ ]  Youth Club: Swinton [ ]  Youth Club: Eastwood [ ]  Youth Club: Town Centre | **Mental health and Wellbeing Support:** [ ]  All/ Any – more information required[ ]  1 to 1 counselling [ ]  1 to 1 – Guided self help[ ]  Group mental health support:  Bereavement support [ ]  Group Personal development sessions:  Confidence building, increasing self esteem, AQA qualification[ ]  Group wellbeing programmes:  Wellbeing Recovery Action Planning (WRAP) learning triggers for wellbeing decline and how to self support. [ ]  Group wellbeing programmes:  Escape the Trap (ETT) recognising abuse/ unhealthy relationships |
| Activities: *Please tick if the young person/ parent/ carer would like to be informed when sessions are delivered related to the following activities;* [ ]  Arts based workshops / creative projects [ ]  Outdoor experiences [ ]  Sports sessions[ ]  Holiday activities |
| **Reason for Referral**  |
| Click here to enter text. |
| **Any other information**  |
| Click here to enter text. |
| **SIGNING** |
| **I, (the referrer) acknowledge the information above and agree to this referral being made.**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **I, (the parent/guardian) acknowledge the information above and agree to this referral being made.** **I give consent for this form to be shared with organisations within the project for the purposes of this project only.*** I consent to my child having their photo or video taken within the project. [ ]  Yes [ ]  No
* I consent to photos of videos taken of my child being used for the purpose of promoting, monitoring, and evaluating the project. [ ]  Yes [ ]  No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **I, (the participant) acknowledge the information above and agree to this referral being made.**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |

**Please return your completed form to** **zoe.cartwright@varotherham.org.uk**

**Smiles for Miles Base Project – Additional Information Form**

The following fields are not compulsory but we would appreciate you completing as much information as possible. The information you provide below will be treated in the strictest confidence and will only be used to monitor representation ensure that no particular individual or group of people are discriminated against. This monitoring information (but not the individual form) may also be passed on to other services who need to use it for the same purpose.

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| **ADDITIONAL INFORMATION**   |
| **Religion / Belief**  | [ ]  No religion or belief[ ]  Buddhism[ ]  Hinduism[ ]  Islam[ ]  Sikhism | [ ]  Christianity[ ]  Humanism [ ]  Judaism[ ]  Other, please specify: Click here to enter text. |
| **Are you disabled?**  | [ ]  Yes [ ]  No |
| **Do you have a long term / limiting illness or condition?**  | [ ]  Yes [ ]  No |
| **Do you have a physical or mobility impairment?** | [ ]  Yes [ ]  No |
| **Do you have a sensory impairment?** | [ ]  Yes [ ]  No |
| **Do you have a learning disability or difficulty?**  | [ ]  Yes [ ]  No |
| **Do you have a long-standing illness or health condition?**  | [ ]  Yes [ ]  No |
| **Are you a carer?**  | [ ]  Yes [ ]  No |

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| **OTHER AGENCY INVOLVEMENT**  |
| **Name of Agency**  | **Key Worker Contact Details**  |
| **Agency 1:** [ ]  Early Help [ ]  Social Worker [ ]  Other, please specify: Click here to enter text. | **Name** | Click here to enter text. |
| **Role**  | Click here to enter text. |
| **Contact No.**  | Click here to enter text. |
| **Email**  | Click here to enter text. |
| **Agency 2:** [ ]  Early Help [ ]  Social Worker [ ]  Other, please specify: Click here to enter text. | **Name** | Click here to enter text. |
| **Role**  | Click here to enter text. |
| **Contact No.** | Click here to enter text. |
| **Email**  | Click here to enter text. |
| **Agency 3:** [ ]  Early Help [ ]  Social Worker [ ]  Other, please specify: Click here to enter text. | **Name** | Click here to enter text. |
| **Role**  | Click here to enter text. |
| **Contact No.**  | Click here to enter text. |
| **Email**  | Click here to enter text. |