



# Middle England Care Farm

## Young Person Referral

### Referral type

	Alternate provision - part time	Alternate provision - part time with 1:1 support	Specialist trauma therapy	1:1 Therapy	How many days a week? Please write below
Tick as appropriate					

### Referrer details

Referral made by	Education Authority	Children's service	Health Service	School Referral	Parental Referral
Tick as appropriate					
Contact Name					
Relationship to YP					
Address					
Telephone					
Email address					
Finance contact					
Finance email for invoicing					

### Young person

Young persons name	
D.O.B	
YP Address If a care facility please include the details	

YP telephone contacts	
If multiple guardians please include the separate names, relationship status and contact numbers	

Are the parents/guardians aware of this referral?      YES/NO please delete as appropriate

### Parent/Guardian details (if different from referrer details)

Contact name(s)	
Relationship status	
Address	
Telephone	
Email	

### GP details

GP Practice	
Address	
Doctor name	
Telephone	

Does the YP have an ECHP      YES/NO

Does the YP have SEND      YES/NO

Is the YP in the care of the local authority      YES/NO

IS the YP currently on any medication      YES/NO  
(Please state)

Is the YP aware of this referral      YES/NO  
How does the YP feel about the referral if they are aware?



**Reason for referral** - Please outline the reasons for making this referral. Please include any concerns, previous therapeutic interventions, barriers with current engagement and education and any current needs. Also include if the student displays anxiety and/or any form of aggression.

**Protective factors** - Please detail any skills, coping strategies and additional support the YP currently has

Are there any medical or physical issues that may make care farming difficult, given that we are mostly outdoors and some activities are strenuous.

Name of referrer	
Position held	
Signed	
Date	