We take Safeguarding seriously and this form is *not a simple referral form* it has been devised to inform safeguarding in case of emergencies. All the boxes on this form must be either clearly marked "none" or have comments added Failure to do so may result in the referral being returned for further information

Which Service are you referring from?

Name of your service	Official Service Address	Service Contact Telephone	Date of this referral

Who is making this Referral?

Your Full Name	Your Telephone / mobile number	Your email Address	Date the student had an induction

Who is being Referred to us ?

Student Name	
Date of Birth	
Students Ethnicity	
Students home address	
Student Telephone number	
Emergency contact name	
Emergency contact telephone number	

What would your client like to engage with ?

Cycle Technicians Workshop	YES	NOT THIS TIME THANKS
Arts and Design Workshop	YES	NOT THIS TIME THANKS
Business Acumen and I.T.	YES	NOT THIS TIME THANKS

Ceracycloan , Ground Floor, Swallow Mill Business Centre, Swallow Street,
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0161 474 0990
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Please tell us all risk Factors *(please ensure this information is correct and as up to date as possible)*

Is the Student on a EHCP	**Yes**	**No**	(If yes also forward the EHCP)
Any known allergy risk	**Yes**	**No**	If yes please give detail
Any known risk to staff	**Yes**	**No**	(If a risk assessment is available please forward)
Any known risk to self	**Yes**	**No**	(If a risk assessment is available please forward)
Is the student taking medication	**Yes**	**No**	If yes, please explain MEDS
Diagnosed conditions	**Yes**	**No**	If yes, please explain conditions
Any behavioural, attitude and motivational issues	**Yes**	**No**	If yes, please tell us more
Any other personal risk or concern	**Yes**	**No**	If yes, please tell us more
Consent for Photographs permitted internet, newsletters, magazines *in keeping with safeguarding*	**Yes**	**No**	
Final check… is there a Risk assessment to accompany this referral form?	**Yes**	**No**	If yes, state which RA's
Positive Factors i.e. hobbies / interests please list below			

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When would you like this referral to start from and end?

What date would you like the referral to start?	
If there is an end date, please state the preferred date	
If an end date is unsure and a bespoke arrangement is required please contact us to discuss further	

Feedback and Reporting contact/s….

Provide email address/es for us to send feedback and reports	

Billing Information…

Provide a contact Name within your accounts department	
Provide your accounts department Telephone number	
Provide us with at least 2 x Email contacts for billing purposes	

It is important that we receive the correct information to ensure the correct levels of knowledge and support are in place i.e. 1 to 1 supervision and general safeguarding procedures.

***Please Note:** Once referred if the individual's behaviour does not match the risk factors detailed on this referral form, you will be contacted, this may result in fees being altered to match the Risk factors, Risk Assessments or Educational Health Care Plan needs.*

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