

Phone	01442 300185	Email	bookings@supportinglinks.co.uk	Mobile:	07512 709556
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I am referring myself	<input type="checkbox"/> Yes	I am referring someone else	<input type="checkbox"/> Yes
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6 Week Course	<input type="checkbox"/> Talking Additional Needs	<input type="checkbox"/> Talking Teens	<input type="checkbox"/> Talking Anxiety	Course ID:	
	<input type="checkbox"/> Talking Families	<input type="checkbox"/> Talking Dads	<input type="checkbox"/> Talking Anger		

All personal information taken, for the purposes of making this booking, will be held securely in accordance with our GDPR Policy, a copy of which is available on request.

Parent/Carer Name					
Address					
Postcode					
Mobile Phone			Email		
White <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Gypsy / Roma <input type="checkbox"/> Any Other White background	Black <input type="checkbox"/> Caribbean / British Caribbean <input type="checkbox"/> African / British African <input type="checkbox"/> Any other Black background	Asian <input type="checkbox"/> Indian / British Indian <input type="checkbox"/> Pakistani / British Pakistani <input type="checkbox"/> Bangladeshi / British Bangladeshi <input type="checkbox"/> Any other Asian background	Mixed <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Another other mixed background	Other <input type="checkbox"/> Chinese <input type="checkbox"/> Arab <input type="checkbox"/> Any other ethnic background <input type="checkbox"/> Not disclosed	

Parent/Carer Needs Is there anything that we need to know about you that will help us to support you? Please provide details.	<input type="checkbox"/> Communication and learning e.g. language, writing or reading	
	<input type="checkbox"/> Mobility or physical issues e.g. vision/hearing impairment	
	<input type="checkbox"/> Emotional Wellbeing e.g. anxiety or mental health	

	Age	SEN or Disability	Children's Needs: Please include physical, emotional, mental health or behavioural concerns.
1		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	
2		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	
3		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	
4		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	
5		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	
6		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> EHCP	

Family Needs It helps us to know some brief details about why you are asking us for help. All information is treated with the strictest of confidence.	<input type="checkbox"/> Risky behaviour	
	<input type="checkbox"/> Aggressive behaviour	
	<input type="checkbox"/> Addiction	
	<input type="checkbox"/> School attendance	
	<input type="checkbox"/> Parental conflict	
	<input type="checkbox"/> Boundaries	
	<input type="checkbox"/> Child with complex needs	
<input type="checkbox"/> Abusive behaviour		

Please provide any other information about your reason for referral here: e.g. What do you hope to gain or understand? What are you hoping to change?	
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Existing Support Please provide brief details if any support from these places has been received in the past year.	<input type="checkbox"/> Children's Services: Child Protection/Safeguarding	
	<input type="checkbox"/> Children's Services: Child in Need	
	<input type="checkbox"/> Early Help/Intensive Families/FFA	
	<input type="checkbox"/> School Family Support Worker	
	<input type="checkbox"/> Family Centre Outreach	
	<input type="checkbox"/> CAMHS/Step 2 (for mental health)	
	<input type="checkbox"/> CAMHS/Paediatrician (for ASD/ADHD)	
	<input type="checkbox"/> Health Visitor or School Nurse	
<input type="checkbox"/> Other (please state):		

Please return your completed referral forms to: bookings@supportinglinks.co.uk

For Professional Referrals ONLY			
Your name:		Position	
Email:			Please confirm the date upon which you explained this to your client
Phone:			
To refer a client to our parenting courses, please first check the course you wish them to attend by looking on our website for our current course offers: http://www.supportinglinks.co.uk/whatson.html	I have have spoken to my client about this course and they are happy to attend	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	My client can attend all the sessions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If there is a history of drug/alcohol abuse, my client knows that they will not be allowed to attend the course if they arrive under the influence of any substance.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
	To help us be safe and appropriate please inform us if this family has a history of domestic abuse, drug and/or alcohol misuse or mental health issues.		
PLEASE SUBMIT SECURELY USING HERTS FX (PREFERABLY) OR PASSWORD PROTECTED EMAIL			

Whilst we are happy to take your referral, the booking will only be finalised once we have spoken to the client. We will attempt to contact your client three times after which we will revert to you and ask that your client contacts us should they wish to attend a course. We only confirm bookings with the client themselves. You may wish to print this form to pass to your client, so they have the relevant information to confirm the booking.