|  |
| --- |
| **Participant Contact Details**  |
| Full Name |  | Gender  |  |
| Email Address |  | Date of Birth |  |
| Contact Number  |  | Age |  |
| Home Address including postcode |  | Borough |  |

|  |
| --- |
| **Referral Agency Contact Details**  |
| Name of Referring Worker |  | Name of Agency |  |
| Name of key worker (if different) |  | Address |  |
| Contact Number  |  | Email Address |  |
| Nature of support given |  |

|  |
| --- |
| **Participant Support Needs**  |
| **Does the participant have any:** *(Please circle any appropriate)* | Physical Disability Learning Difficulty Offending History Medical Condition Emotional/ Behavioural Difficulties Care LeaverYoung Carer Drug and Alcohol Issues Mental Health DifficultiesYoung Parent / Parent to Be Homeless Other |
| **Please give details, including any known risks / issues** |  |
| **What is the main purpose of this referral?** |  |
| **Is the client currently attached to any other organisation or programme?**  |  |
| **Please confirm the following:** |  |
|  The Participant has Valid ID (British or EU Passport, Biometric Visa, Birth Certificate, National Insurance Letter , Home Office Letter)  |[ ]
| The participant is resident in one in Southwark or is Southwark resident currently aboding in another Borough  |[ ]
| The participant is legally resident in the UK and able to take paid employment in a European Union Member state   |[ ]

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(By referral agency)

Please send completed referrals to

YPproject@stgilestrust.org.uk

Any questions please call the Your Path Project Team on: 020 7708 8063