|  |  |  |  |
| --- | --- | --- | --- |
| **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 Leaver  Young Carer Drug and Alcohol Issues Mental Health Difficulties  Young 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](mailto:YPproject@stgilestrust.org.uk)

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