**Referral Form**

**1/Details of person being referred**

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Date of referral

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Name of child

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Parent /Carer contact details:

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Email

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Phone

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Date of Birth

Age Group:

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2 – 5

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5 – 8

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8 – 11

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Name of school

(if known)

**2/Nature of referral**

Reason for referral

If possible, include the intended outcomes of the referral and the service you think will best support the child/family.

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Nature of support required (if known)

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Is there anything that we should be aware of? Please include any potential risks.

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Is the child receiving support from any other agency? If so, please specify. Include if under a child protection plan or whether Looked After.

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**3/Details of Referrer**

Name of person referring

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Job Role

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Contact email/phone number

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Consent given to share information with Bolton Together and wider agencies offering support for EHWB. Consent must be given before referring.

Please send the completed referral form to the email of the provider you wish to refer to. If you have any queries about the form or the process email boltontogether@boltontogether.org.uk or contact **07547409726.** From March a one point of referal will be established and an updated form will be available