

Referral form

**Our services are for children and young people aged between 5 and 24 years old, living in Edinburgh who are neurodivergent, including diagnoses of autism, ADHD and intellectual disability.**

**We accept referrals directly from children and young people, their parents or professionals.**

**Please complete this form to refer yourself or a child or young person to our project. With any queries, please contact us at** **NDwell@barnardos.org.uk**

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| **About the child or young person** |
| Name |  |
| Address inc. postcode |  |
| Contact number |  |
| Email |  |
| Date of birth |  |
| School (if applicable) |  |
| Named person (if applicable) |  |
| Diagnosis |  |

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| **About the parent/carer (if applicable)** |
| Name |  |
| Address |  |
| Contact number |  |
| Email |  |
| Relationship to child/YP |  |

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| **About the referrer if a professional (if applicable)** |
| Name of referrer |  |
| Job title |  |
| Organisation/service |  |
| Address |  |
| Phone |  |
| Email |  |
| Is the C/YP or their parent aware you are making the referral? |  |

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| **About key professionals involved (for example SLT, OT, Ed Psych, Social worker, CAMHS)** |
| **Name** | **Role** | **Contact details** |
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| **Please describe below why you’re making this referral**  |

**Please indicate which of these areas you or the child/young person you’re referring would like support with?**

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** |

**Please email your completed form to** **NDwell@barnardos.org.uk**

**We will be in touch to confirm receipt of the referral so please contact us if you don’t hear from us.**

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***For office use only***

|  |  |
| --- | --- |
| Date referral received |  |
| Data capture completed |  |

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| **Outcome of referral** |  |
| Service(s) referred to: |  |
| Did not progress  |  |