NEW BEGINNINGS CARE GROUP

Referral Form

SERVICE TYPE: ☐ **Children Services** ☐ **Semi Independent Service**

SECTION 1 – REFERRER DETAILS

Job Title / Role *

Organisation / Local Authority *

Team Name

Work Email

Work Phone

Full Name

SECTION 2 – YOUNG PERSON'S DETAILS

Young Person's Initials

Date of Birth

Gender Identity

Ethnicity

Legal Status

Placement Type Needed

Requested Start Date

Current Location / Borough

SECTION 3 – CARE & SUPPORT NEEDS

Background & Presenting Needs

Education / Current School

Health / Medical Needs

Known Risk Factors / Behaviours

Additional Information

EMERGENCY REFERRAL

☐ Emergency Referral

URGENCY LEVEL

☐ High (Immediate) ☐ Medium (Within 24 Hours) ☐ Low (Within 1 Week)

Emergency Details

Out-of-Hours Contact:	+44 2073 781777 referrals@newbeginningscare.co.uk	*We aim to respond within 2 hours for emergency referrals.*

Authorised Signature

Date