



Exceptional Care Referral Form

Children's Residential Services

Details of Referral Source

Date of referral	
Person making referral	
Telephone number	
Email address	
Local authority	
Address	
Length of accommodation required	

Details of Child/Young Person

Child Young/Person's name	
Gender	
Date of birth	
Place of birth	
Ethnic origin	
Height	
Weight	
NHS Number	
Diagnosis	
Additional medical needs or disabilities	
Medication	
Continence needs	
First language	

Name(s) of parent(s) or person(s) with parental responsibility)	
Telephone number	
Present Address	
Name of present primary carer	
Legal status of young person	
Known allergies or intolerances?	
Dietary requirements	
Disability register (if yes please give details)	

Please summarise below, the main reasons a placement is required

Please explain the primary aims and objectives of the placement sought

Please describe short term and long term aims and aspirations for the young person
Short term

Long term

Details of Family

Mother's Name:	Father's Name:	
Date of Birth:	Date of Birth:	
Telephone No:	Telephone No:	
Address:	Address:	
Siblings		
Name	Date of Birth	Address
Other Significant Adults		
Name	Date of Birth	Address
Details of any restrictions on contacts:		

Cultural and religious requirements (please give details)

Details of previous placements

Record of Placements While Being Looked After By Local Authority				
Type of placement and name of carer	Address	From	To	Reason for leaving

Skills

Skill	Description/level of support required
Communication – understanding other people	

Communication – expressing themselves (Speech, signing, PECS etc)	
Reading and writing skills	
Self Care	
Meal Times	
IT and technology skills	
Mobility	
Independence Skills	
Socialising	
Behaviours	
Sleep Pattern	
Any Other Relevant Information	

PRESENTING BEHAVIOUR OF CHILD/YOUNG PERSON

The decision to place a child/young person depends on accurate information about their behaviour. Any placement will be at risk of immediate closure should this information subsequently prove inaccurate.

Question	No	Yes	Details (continue on a separate sheet if necessary)
Is there any physical aggression towards other people?			
Is the young person likely to bully others?			
Is the young person likely to be victimised?			
Is there any history of verbal aggression?			
Is there any history of damage to property or possessions?			
Any history of sexual/emotional abuse?			
Is the young person currently on the "Child Protection Register"?			
Is the young person sexually active?			
Does the young person demonstrate sexualised behaviour?			
Is there any history of drug use?			
Is there any history of self-harm?			
Does the young person display sexist or racist views?			
Does the young person understand consequences?			
Can the young person build friendships with peers?			
Does the young person have ritualised obsessive behaviour?			
Does the young person present with serious phobias/fearfulness?			

Please describe any challenging behaviours; including triggers and frequency/severity of behaviours.			
Is the young person currently following a behaviour management plan?			Yes/No
If so briefly describe:			
Has the young person required physical interventions in the past?			Yes/No
Please describe/identify techniques:			
Levels of support deemed necessary for young person			
In The Past	1:1	Currently	1:1
	2:1		2:1
Other give details:		Other give details:	

Please give details of any criminal record held, or criminal offences committed.	
Please detail any acts of arson or fire-starting behaviours.	

Please detail any other involvement with the police or criminal justice system.

KEY AGENCIES

Key Agencies (complete contact details if currently working with child/young person)	
Agency	Contact Name & Telephone No.
GP	
Social Worker	
Y.O.T	
School Nurse	
H.V.	
Psychiatrist/ Psychologist	
Police	
Dentist	
Community Paediatrician	
Speech and Language Therapy	
Physio/OT	
Behaviour Support Team	
CAHMS	
Other	

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EDUCATION

Name & address of current School		
Telephone Number		
Name of Head Teacher		
Name of Class Teacher		
Name of SENCO		
Please specify level and type of support received in School:		
Please highlight the young person's main achievements in education:		
Any academic or vocational qualifications held by young person		
Date	Subject Area	Qualification

For Office Use Only

Form received by:

Date and time received:

Follow up actions: