

**Referral Form 2024/2025**

Please complete this form and return to [Director@newleafburton.co.uk](mailto:Director@newleafburton.co.uk)

Or post to: New Leaf AP, 5 St Paul’s Square, Burton-on-Trent, Staffordshire, DE14 2EF For Attention Of: Karen Nicoll Telephone: 01283 568616

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSON MAKING THIS REFERRAL - PLEASE PROVIDE YOUR DETAILS** | | | | | | | | | | | | | | | | |
| **Contact Name:** | | |  | | | | | | | | | | | | | |
| **Contact Number:** | | |  | | | | | | | | | | | | | |
| **Email Address:** | | |  | | | | | | | | | | | | | |
| **Best time to contact:** | | |  | | | | | | | | | | | | | |
| **STUDENT DETAILS** | | | | | | | | | | | | | | | | |
| **Full Name:** | | | | | |  | | | | | | | | | | |
| **Age:** | | | | | |  | | | | | | | | | | |
| **DOB:** | | | | | |  | | | | | | | | | | |
| **Current School Year :** | | | | | |  | | | | | | | | | | |
| **Male/Female:** | | | | | |  | | | | | | | | | | |
| **Address:** | | | | | |  | | | | | | | | | | |
| **Name of parent/guardian:** | | | | | |  | | | | | | | | | | |
| **Contact number for parent/guardian:** | | | | | |  | | | | | | | | | | |
| **Email address of parent/guardian:** | | | | | |  | | | | | | | | | | |
| **Please answer with Y or N in the white column opposite** | | | | | |  | | | | | | | | | | |
| **Looked After:** | | | | | |  | | | | | | | | | | |
| **Child Protection Plan:** | | | | | |  | | | | | | | | | | |
| **Child in Need:** | | | | | |  | | | | | | | | | | |
| **Is the pupil(s) on the SEN Register:** | | | | | |  | | | | | | | | | | |
| **Does the pupil(s) have an EHCP:** | | | | | |  | | | | | | | | | | |
| **Is the pupil(s) under EHCN Assess:** | | | | | |  | | | | | | | | | | |
| **Is the pupil(s) eligible for Free School Meals:** | | | | | |  | | | | | | | | | | |
| **Which of these areas need support?** | | | | | |  | | | | | | | | | | |
| **Communication & Interaction** | **Cognition & Learning** | | | | **Social, Emotional & Mental Health** | | | **Sensory and/or Physical** | | **Medical** | | | **Other (specify)** | | | |
|  |  | | | |  | | |  | |  | | |  | | | |
| **Current Registered School:** | | | |  | | | | | | | | | | | | |
| **Reason for Referral:** | | | |  | | | | | | | | | | | | |
| **Pupil Profile:**  Include the pupil’s views, areas of enjoyment, strengths, interests, agency involvement etc. | | | |  | | | | | | | | | | | | |
| **Current Attainment Levels (if known):** | | | |  | | | | | | | | | | | | |
| **Additional Information:**  Any specific needs that need to be met e.g. religion, English as a second language etc. | | | |  | | | | | | | | | | | | |
| **Any risks that need to be considered:** | | | |  | | | | | | | | | | | | |
| **Access to accredited qualifications /examinations required (GCSE, ASDAN)** | | | | | | **Yes** | | | | | **No** | | | | | |
| **Proposed Start Date:** | |  | | | | **Proposed End Date:** | | | | |  | | | | | |
| **Total number of hours per week:** | | | | | |  | | | | | | | | | | |
| **Please place a cross in preferred days:** | | | | | | **Mon** | | | **Tues** | **Wed** | | **Thurs** | | **Fri** | |
| **Hours to be delivered per day:**  **(maximum of 4 hours per day)** | | | | | |  | | |  |  | |  | |  | |
| **INTERNAL USE OFFICE ONLY** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Visit arranged? Date and Time | | | | | | |  | | | | | | | |
| Trial day arranged? Date and Time | | | | | | |  | | | | | | | |
| Pre-admission Risk Assessment completed? | | | | | | |  | | | | | | | |
| Start date agreed? | | | | | | |  | | | | | | | |
| Learner Contract agreed and signed by all parties? | | | | | | |  | | | | | | | |