



Jigsaw Family Support

REFERRAL FORM

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Child/ Young Person Details

Full Name:			
Age:		DOB:	School Year:
Identifies as:			
Ethnicity:			
Address:			
Parent/ Carer Details:			
Contact Telephone:			
Email:			
Current Educational Setting:			

Tick all that apply:

SEN or Disability		EHCP		Care Experienced		EHA		CIN		CP plan	
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Involved Agencies

Name	Organisation	Contact Details

Reason for Referral

At risk of Permanent Exclusion		
Permanent Exclusion		
Non-Attendance		
Medical Concerns		
Not in Education		
Other		

Please provide as much information as possible to support your referral

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Anticipated outcomes from Jigsaw Family Support services

Please provide any known risks or considerations for this child/ young person or

Please list additional documentation which is attached in support of this referral (EHCP, EHA, Pupil Passport etc)

Addition information attached: YES / NO

Referrer Info

By completing and signing this referral form, you are confirming that you have both consent and permission to share the information contained with Jigsaw Family Support.

Name	
Position	
Organisation	
Contact Email	
Contact Telephone	

Please email referrals@jigsawfamilysupport.uk via secure method (Egress or password protection) once completed.

**Office use only**

Date Referral Received	
Referral accepted	
Family Support Worker assigned	
Summary	
Date of commencement	
Summary	

Involvement End Date	
Summary	