# From:

**Referral in to SNAP Cymru Early Help**



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| Organisation Name: |
| Organisation Contact: |
| Address: |
| E-mail: |
| Telephone: | Referral date: |

# Child / Young Person:

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| --- |
| Name: |
| D.O.B: | Gender: | Ethnicity: |
| Child / Young Person’s Disability / Diagnosis: |

**Parent / Carer:**

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| --- |
| Name: |
| Address: |
| Post Code |
| Telephone: | Mobile: |
| E-mail: |

**School:**

|  |
| --- |
| Name: |
| Language: |

Contact name/email:

**Details of referral:**

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| --- |
| Who is currently working with the family? What support are they providing? |
| What is going well? What are we worried about? |
| What needs to happen? Issues for SNAP Cymru |

## Are there any special requirements necessary to work effectively with this family? (E.g. accessibility / language)

**Consent Statement**

1. I/parent agree to the use and sharing of information with SNAP Cymru
2. I/parent understand(s) that there may be circumstances where SNAP Cymru will still share your/their information with other agencies without your/their agreement. This will include where it is necessary to do so to safeguard your child or yourself
3. I/parent understand(s) that I/they can withdraw consent at any time

|  |  |
| --- | --- |
| Parent / Carer / Young Person – | Professional: Consent from the parent to make this referral has been made? |
| Signed: | Signed: |
| Date: | Date: |

# Please send referral to: early.help@snapcymru.org

## We will acknowledge receipt 0f the referral and contact the parent within 5 working days

SNAP Cymru – Mar 21