EXPLORERS HORIZONS

PA Referral Form

Personal Details

Name:

Date of Birth:

Address:

Parent/Carer:

Telephone:

Email:

Preferred Communication Method:

Diagnosis

☐ Autism

☐ ADHD

☐ Learning Disability

☐ SEMH

☐ Other

Details:

Emergency Contacts

Name:

Relationship:

Telephone:

GP Details

GP Surgery:

Telephone:

Support Requested

☐ Community Access

☐ Life Skills

☐ Social Support

☐ Leisure Activities

☐ Travel Training

☐ Educational Support

☐ Respite

☐ Other

Goals

What would you like Horizons to help achieve?

Communication Needs

Preferred communication:

Visual supports required?

Makaton?

AAC?

PECS?

Other:

Sensory Needs

Noise:

Touch:

Food:

Crowds:

Lighting:

Other:

Behaviour Support

Triggers:

Early warning signs:

Helpful strategies:

Medical Information

Medication:

Allergies:

Epilepsy:

Dietary needs:

Other:

Consent

I consent to Autism Explorers CIC assessing this referral.

Signed:

Date: