EXPLORERS HORIZONS

PA Referral Form

Personal Details		
First Name:		Surname:
Date of Birth:		
Address:		
Parents/Carers:		
Parents/Carers Address if different from Childs		
Telephone:		
Email:		
	Preferred Communication Method:	

Emergency Contacts	
First Contact Name: Relationship: Telephone: Email:	Second Contact Name: Relationship: Telephone: Email:

GP Details	
GP Surgery: Telephone:	
Diagnosis	
	☐ Autism ☐ ADHD ☐ Learning Disability ☐ SEMH ☐ Other Additional Details:
Medical Information	
	Medication: Allergies: Epilepsy: Dietary needs: Other:

Support Requested	
	☐ Community Access ☐ Life Skills ☐ Social Support ☐ Leisure Activities ☐ Travel Training ☐ Educational Support ☐ Respite ☐ Other
Communication Needs	
	Preferred communication: Visual supports required? *For example Makaton, Signing, ACC, PECs* Other:
Sensory Needs	
	Noise: Touch: Food: Crowds: Lighting:
Behaviour Support	
	Triggers: Early warning signs: Helpful strategies:

Goals	
	What would you like Horizons to help achieve?
Consent	
	I consent to Autism Explorers CIC assessing this referral. Signed: Date: