**Connect Referral Form**

Peer Support Service for Young People aged 11 – 18 years with Autistic Spectrum Condition diagnosis or on the ASC pathway. Residents of Maidstone and Tonbridge and Malling Boroughs **only**.

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| **Young Person’s Full Name:** |  |
| **Known as:** |  |
| **Gender / Pronouns:***(please state if gender identity is different to assigned at birth)* |  |
| **Date of birth:** |  |
| **Address:** |  |
| **GP surgery:** |  |
| **NHS number:**  |  |
| **Diagnosis/Health Conditions:** |  |
| **Dietary requirements:** |  |
| **Parent/Carer full name:** |  |
| **Contact telephone number:** |  |
| **Parent/Carer Email:** |  |

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| **Are there any risk factors associated with home visiting this young person or this young person attending activities?:** | Yes / No |
| If yes, please specify: |

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| **Has the Young Person or their Parent/Carer agreed to be contacted by the Connect Youth Programme Lead?** |
| Yes / No |
| **Has the Young Person or their Parent/Carer agreed to receive monthly bulletins via email?** |
| Yes / No |

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| **Please give the reason for referral and any relevant additional information concerning the Young Person:** |
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**Please email referrals to Amelia.Kury@involvekent.org.uk**