CYGNET REFERRAL FORM

Child's Name:	Date Of Birth:	Gender M / F	NC Year Group:
Please complete all contact details **Parent/Carer name and address:** **Telephone Number:** **Landline** **Mobile** **Email Address:**		**School/Setting:**	
Is the child a 'Child Looked After'? Yes / No			
Does the child have a diagnosis of autism? Yes / No If Yes: Which Service/agency undertook the diagnostic assessment? Where was the diagnosis made? Approx date of diagnosis:			
Does the child have a Statement/EHCP? Yes / No			
Does the child have any additional learning difficulties or disabilities? Yes / No If yes please summarise:			
Do either parents have any special needs?			
Do either parents have issues working in small groups?			
Is the child known to CAMHS? If Yes, is this an ongoing CAMHS case?			
Do you know if any other agencies are involved with the family?			
Is there any additional information you feel we may need to be aware of?			
Name of referrer:	Signature :	Date :	
Please return by post to: STARS Cygnet Programme:. Please return it to STARS Administration, STARs – Autism Outreach. PO Box 837. Leeds. LS1 9PZ or starsteam@leeds.gov.uk			