**Office use only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Ref No.** |  | **Courses requested** |  |
| **List** |  | **Lanc/More** |  |
| **Contacted** |  | **Accepted** |  |

****

**A six week (18 hrs) parenting support programme for parents/carers of children aged 5-18 on the autistic spectrum in North Lancashire.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CYGNET GROUPEnrolment f o r m | | | | | | | | | |
| If this enrolment form is not being completed by parents or carers, please ensure that all professional referrals have obtained permission from them to pass their details onto us.Thank you | | | | | | | | | |
| BASIC INFORMATION | | | | | | | | | |
| Date: | Referrer (if not Parent or carer)  Address:  Tel number:  Email: | | | | | | | | |
| **INFORMATION ABOUT PARENTS/CARERS** | | | | | | | | | |
| **Parent/ Carer** | | Relationship to child: | | | | | | | |
| Title: | | Name: | | | | | | | |
| Ethnicity: | | | | Religion: | | | Preferred Language: | | |
| Home Tel: | | | | Mobile: | | | Email: | | |
| **Parent/Carer** | | Relationship to child | | | | | | | |
| Title: | | Name: | | | | | | | |
| Ethnicity: | | | | | Religion: | | | Preferred Language: | |
| Home Tel: | | | | | Mobile: | | | Email: | |
| address information | | | | | | | | | |
| Address: Post Code: | | | | | | | | | |
| **Do you have a disability or is there additional Information you want to provide to help you attend a group: (i.e. access to a lift, literacy support)?** | | | | | | | | | |
| **Preference for group** | | | | | | | | | |
| Lancaster  🗆 | | | Morecambe / Heysham 🗆 | | | Day 🗆 | | | Evening 🗆 |
| **CHILD’S INFORMATION** | | | | | | | | | |
| Name: | | | | | | Date of Birth: | | | |
| Diagnosis: | | | | | | Date of Diagnosis: | | | |
| Diagnosed by whom: | | | | | | Name of School: | | | |
| **Additional Information about your child/child in your care including what issues you are experiencing.** | | | | | | | | | |
| **Do you have other children in your household? If so would you be interested in attending a further 3 sessions around siblings? Yes**  🗆 **No**  🗆 | | | | | | | | | |
| **No. of other children and ages** | | | | | | | | | |
| **If your child with an Autistic Spectrum Condition is over age 9, would you be interested in extra sessions around puberty, sexual wellbeing and relationships at a later date? Yes**  🗆 **No**  🗆 | | | | | | | | | |

**I agree to the programme coordinators processing information about me in order to provide the services.**

**I understand I may review this consent at any time. Please sign if you are happy for us to keep your details on our system.**

**I understand I must be able to commit to ALL 6 sessions of the programme to be given a place on the course.**

**Completion of the referral form is not a guarantee of a place on the course. Confirmation of your place will be sent via post/email prior to the start date.**

**Parent/Carer 1**

**Name:**

**Signature: Date:**

**Parent/Carer 2**

**Name:**

**Signature: Date:**

|  |  |
| --- | --- |
| admin use | |
| Date entered on Programme List: | Received via: |
| Please return to:  Lucy Ellis (Cygnet Coordinator)  Barnardo’s Cygnet Programme  c/o Lune Park Children’s Centre  Owen Road  Lancaster  LA1 2LN  Tel: 07873818153  Email: cygnetsnorthlancs@gmail.com | Date received: |



