PEMBROKESHIRE SIBLING GROUP

Elizabeth Edwards
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Email: psg.referrals@gmail.com
Charity Registration No: 1076083

REFERRAL FORM

Please answer all questions and return this form to the address above;

Name(s) and Date(s) of Birth for child(ren) being referred. (Children must be aged 7 or over)		
Name of Parent or Guardian		
Address of Parent or Guardian		
Telephone Numbers	Home	
	Mobile	
	Emergency	
Email Address		
Details of recognised professional supporting the referral: (E.g. Teacher, Social Services Professional, GP, Health Visitor or other health professional)	Name: Position: Telephone Number: Signed: Date:	

To be eligible to receive the services of Pembrokeshire Sibling Group the referred child(ren) must have a brother or sister with a diagnosed disability, chronic illness or additional needs.

Name(s) of disabled child(ren)	
Please describe the nature of the disability, or disabilities.	
In what way does the disability affect the life of the referred child(ren)?	

I give permission for the referred child(ren) to receive the services of the Pembrokeshire Sibling Group and understand that information given will be held under the Data Protection Act for the legitimate purposes of the charity.

Signed: ..... (Parent/Guardian)

Date: .....