



Connect3
 Castleford and Normanton District Hospital
 Lumley Street
 CASTLEFORD
 WF10 5LT



Referral form for Connect3 Programmes

Please ensure this form is completed in full, if it is not it may delay allocation or have to be returned to you for further information.

Child's surname _____ Child's forename _____

Child's Age _____ Date of birth ____/____/____ Male Female

Parent/carer surname _____ Parent/carer forename _____

Child's address _____

Contact telephone: Home _____ Mobile _____

School attended _____

Referrer details: Name _____ Title _____

Contact address _____

_____ Tel _____

Height (if known) _____ Weight (if known) PP _____ BMI (If known) _____

Where did you hear about the programme? _____

Reason for referral (give details) _____

Additional information, i.e. complex or additional needs, etc (give details) _____

Connect3 use only:

Allocated? C3 C3A C3J C3M No (reason) _____

Initial contact letter sent Yes No Appointment letter sent Yes No

Reply received Yes No Notes requested Yes No

Additional info _____

Attended taster session? Yes No

If no, DNA letter sent and referrer informed? Yes No