

PROJECT REQUEST FORM

MERU project no: _____ (for office use only)



Before applying please check that the project is eligible for MERU's services. See our acceptance criteria on our website: www.meru.org.uk. Alternatively phone us on 01372 725203 or email info@meru.org.uk

Unit 2 Eclipse Estate
30 West Hill
Epsom Surrey
KT19 8JD

Tel: 01372 725203

Fax: 01372 743159

Email: info@meru.org.uk

Website: www.meru.org.uk

- All projects **must** be referred by or with the support of a relevant health care professional who is working with the young person - e.g. an occupational therapist, speech therapist, physiotherapist or paediatrician.
- MERU will consider the referrer to be responsible for ensuring that the product we make is suitable for the young person in their care.

Please note: As a charity we must use our resources carefully, so we cannot take on any project where a commercial solution is available. Please check the marketplace carefully before referring.

Do any of the following apply to the person you are referring. These will affect their priority score:

They have limited life expectancy

Yes No

They are in danger or at risk

Yes No

Their human rights are not being met

Yes No

They are missing out on a valuable life or developmental experience

Yes No



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1. REFERRER'S INFORMATION

NB All referrals must be made or supported by a relevant health professional. If you are not a health care professional, please indicate who is supporting it and provide a letter or other documentation.

Name of person referring: _____

Job Title: _____

Organisation: _____

Address: _____

Postcode: _____

Local Authority: _____

Contact No(s): _____

Email: _____

Signature: _____

Date: _____

If the project is for multiple children, please go straight to Question 5

2. Cont...

Parent/guardian/name(s): _____

Relationship to young person: _____

Address: _____

Postcode: _____

Email: _____

Home phone: _____

Mobile phone: _____

Please describe the young person's disability and any relevant medical history: _____

How does their disability affect them?

2. INFORMATION ABOUT THE YOUNG PERSON BEING REFERRED

Please complete fully

First name(s): _____

Surname: _____

Date of birth: _____

Male/female: _____

Home local authority: _____

3. SCHOOL/COLLEGE INFORMATION

Name _____

Address: _____

Postcode: _____

Contact No(s): _____

Email: _____

