Inclusion,
Confidence,
Belonging

# REFERRAL FORM

***Please attach any supporting documentation***

**Please complete all sections and return to**:

Referral Co-ordinator
CHOICE
Elim Church
Kerrier Way
Camborne
Cornwall
TR14 8FH

Tel: 01209 714782
Email: choice@elimcamborne.org.uk

## Referred By:

| | |
|---|---|
| **Date** | |
| **Name of person making referral** | |
| **Designation** | |
| **Organisation (If applicable)** | |
| **Address** | |
| **Contact number** | |
| **Email address** | |
| **Where did you hear about us?** | |

## Service User Details

| | |
|---|---|
| **Full Name** | |
| **Date of Birth/Age** | |
| **Gender** | |
| **Ethnic Origin** | |
| **Religion** | |
| **NHS Number (If Known)** | |
| **Current Address** | |
| **Telephone Number** | |
| **Current Medication** | |
| **Allergies(if applicable)** | |

## FAMILY CONTACTS

| | |
|---|---|
| **Next of Kin/Significant family member** | **Relationship:** |
| **Address** | |
| **Telephone Number** | |

## PROFESSIONALS/AGENCIES INVOLVED

| **Designation** | **Name** | **Contact Number** |
|---|---|---|
| **Case coordinator** | | |
| **Social Worker** | | |
| **CPN** | | |
| **GP** | | |
| **Other (Please State)** | | |
| | | |
| | | |

## FUNDING

| | |
|---|---|
| **Budget Holder (eg. Local Authority/ Personal Budget/** | |
| **Contact Name** | |
| **Address** | |
| **Telephone Number** | |
| **Fax** | |
| **Email Address** | |

**Has funding been agreed?** **Yes** ☐ **No** ☐ **In principle** ☐

## LEGAL STATUS

Is the service user subject to Deprivation of Liberty Safeguards?

Yes ☐ No ☐ If yes, please complete the following:

| | |
|---|---|
| **Supervisory Body** | |
| **Contact Name** | |
| **Contact Number** | |
| **Date Commenced** | |

## CURRENT STAFFING LEVELS

| | |
|---|---|
| **DAY** | |
| **NIGHT** | |
| **In Community** | |
| **Any specific requirements** | |

## Tell us a bit about yourself

Skills, Talents, Interests, what would give you a great day?

**What has the Local Authority said are your Assessed Needs?**

**Support Plan Agreed by you and Adult Care?**

**Yes** □ **No** □

## Reason for Referral

## Required Outcomes

## Times required

| Day | Day Session | Am Session | PM Session | Evening |
|---|---|---|---|---|
| **Monday** | □ | □ | □ | □ |
| **Tuesday** | □ | □ | □ | □ |
| **Wednesday** | □ | □ | □ | □ |
| **Thursday** | □ | □ | □ | □ |
| **Friday** | □ | □ | □ | □ |
| **Saturday** | | | | □ |
| **Sunday** | | | | □ |

**Activites**

Would you like to access activities only (No Support) Yes □ No □

If you answered yes a list of current activities and associated costs will be given to you.

## BACKGROUND DETAILS

***Please summarise and attach any relevant information***

### Family Circumstances

### Personal Circumstances

## Medical History/Including past treatments

*Please give dates where known*

## Communication

How do you/does this person communicate
Please let us know the type of equipment that is used to improve communication if appropriate

| **Current Therapeutic Input**<br>**(please provide details of input offered and level of motivation)** | |
|---|---|
| **1.** | **Psychology** |
| **2.** | **OT** |
| **3.** | **SALT** |
| **4.** | **Intensive Support Team** |
| **5.** | **Physiotherapy** |
| **6.** | **Dietetics** |
| **7.** | **Other** |

## OUTLINE OF RISKS AND BEHAVIOURS

| **Verbal Aggression** |
| --- |
| |
| **Physical Aggression** |
| |
| **Self Harm** |
| |

| Environment |
| --- |
| |
| **Self-Care/Neglect** |
| |
| **Vulnerability** |
| |
| **Theft** |
| |

**Any Other Risks**

Eg. Money, Wandering, Roads, Stranger Danger, Vehicles, Public Transport etc.

**Any other relevant information:**

**Signed:**

**Date: / /**