

Person's Name:

DOB:

Office Use only:
Date received:

Consent							
Is the referred person aware of this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>				If no – please state why? <i>If person lacks capacity, has a Best Interest decision been made – provide details</i>			
Has the referred person consented to this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Care manager/local authority holding responsibility:				Telephone number:			
Reason For Referral							
Please give a summary of the reason why you / the person being referred needs support from a Health and Social Care service in CTPLD. Please be specific and attach any relevant information to help with the referral.							
Who do you think the referral is for? <input type="checkbox"/> Challenging Behaviour Specialist <input type="checkbox"/> Dietitian <input type="checkbox"/> Health Support Worker <input type="checkbox"/> Nursing <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychology <input type="checkbox"/> Speech and Language Therapy <input type="checkbox"/> Social Care Referral (East Berkshire only)							
What are the person's desired outcomes for this referral?							
What supporting documents / reports are attached? (e.g. psychological assessment; health information; educational information etc.)							
Risk Factors: Please tick							
	Past	Present	Not Known		Past	Present	Not Known
Deliberate Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Forensic History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse from Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-Compliance with Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence to Others (verbal) (including professionals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has served in the armed forces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrer's Details:							
Name of referrer:				Professional role / support to the person:			
Address:				Signature of referrer:			
Telephone Number:				Email:			
Other Services Involved							
Other Professionals involved and their roles in supporting the service user (please include contact details)							

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Living environment (current accommodation):

Own Home Family/Carers Home Residential Supported Living Other (Please state).....

Settled Accommodation Indicator:

Is permanent residence settled or non-settled? Settled Non-settled

Employment status:

Employed Unemployed Voluntary Work Supported Work Student Not Applicable Not Known

Weekly hours worked?

Demographic Details

Ethnicity (please tick)

Asian Bangladesh	<input type="checkbox"/>	Ethnic Other	<input type="checkbox"/>
Asian Indian	<input type="checkbox"/>	Mixed White & Asian	<input type="checkbox"/>
Asian Other	<input type="checkbox"/>	Mixed White & Black African	<input type="checkbox"/>
Asian Pakistani	<input type="checkbox"/>	Mixed White & Caribbean	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Mixed Other	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	White Other	<input type="checkbox"/>
Black Other	<input type="checkbox"/>	White Irish	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	White British	<input type="checkbox"/>
Declined to answer	<input type="checkbox"/>		

Marital Status (please tick)

Civil Partnership	<input type="checkbox"/>	Divorced / Person who's Civil Partnership is dissolved	<input type="checkbox"/>
Married	<input type="checkbox"/>	Not Disclosed	<input type="checkbox"/>
Separated	<input type="checkbox"/>	Single	<input type="checkbox"/>
Widowed/Surviving Civil Partner	<input type="checkbox"/>		

Religion: (please tick)

Atheist	<input type="checkbox"/>	Judaism	<input type="checkbox"/>
Buddhism	<input type="checkbox"/>	Islam	<input type="checkbox"/>
Christianity	<input type="checkbox"/>	Sikhism	<input type="checkbox"/>
Hinduism	<input type="checkbox"/>	Any Other belief	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>		

Does this person have a chronic illness or disability? Yes No Prefer not to say

Along term medical condition Mobility problems Sight loss Hearing loss
A Learning Disability Mental ill health Other (Please state).....

Which of the following best describes – gender?

i) Male ii) Female
iii) Prefer to self-describe iv) Prefer not to say

Which of the following best describes – sexual orientation?

i) Straight / heterosexual ii) Lesbian/ Gay iii) Bisexual
iv) Prefer to self-describe v) Prefer not to say

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Please use for any additional information you feel would be helpful

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