**Support Package Referral Form**

Before completing this document, the person must be provided with a copy of the privacy notice

Tick to confirm that the privacy notice has been given

If, following the referral process it is agreed support will not be provided by Accede Support Limited, this document will destroyed.

If, following the referral process it is agreed support will be provided by Accede Support Limited , this document will transfer into the support planning process to meet contractual requirements.

|  |  |
| --- | --- |
| Date Referral Form Completed |  |

**Flow Chart**

**Yes**

**Evidence seen and documented**

**Continue with referral.**

**Yes**

**Is there an**

**IMCA**

**No**

**Does the person have family?**

**Best interest assessment needed.**

**No**

**No**

**Yes**

**Review when section is lifted.**

**Does the person have capacity to understand the referral process?**

**Is the person subject to section under the Mental Health Act?**

|  |  |
| --- | --- |
| **Are you currently subject to a section under the Mental Health Act?** | **Yes / No** |

|  |
| --- |
| **What is your legal status in relation to Capacity?** Please provide details in the box below |
|  |

|  |  |
| --- | --- |
| **Are there any concerns about your capacity to understand the service being offered?**  If Yes detail in the box at the bottom of this page what help the person needs to understand the service being offered | **Yes / No** |

|  |  |
| --- | --- |
| **Is there documented legal evidence of legal lasting Power of Attorney?**  If yes, please provide details in the box at the bottom of this page | **Yes / No / NA** |

|  |  |
| --- | --- |
| **Is there an IMCA or guardian involved?** If yes, please document in the box at the bottom of this page | **Yes / No** |

|  |  |
| --- | --- |
| **Are there any potential Deprivation of Liberty (DOLS) /Safeguarding issues?**  If yes please provide details in the box at the bottom of this page | **Yes / No** |

|  |
| --- |
| **Please provide any additional comments on any of the questions above:** |
|  |

|  |
| --- |
| **Please provide any additional comments on any of the questions above:** |
|  |

|  |  |
| --- | --- |
| **Signed** |  |
| **Position** |  |
| **Date** |  |

**Referral and Confidential Information Sheet**

|  |  |
| --- | --- |
| **Name of Person:** | |
|  | |
| **Current Address:** | |
|  | |
| **Date of Birth:** | **Age:** |
|  |  |
| **Sponsoring or Funding Source:** | |
|  | |
| **Contact Person:** | **Telephone Number:** |
|  |  |
| **Nature of Referral:** | |
|  | |

**Service User Information**

Please provide a brief history of yourself/the person concentrating on the following areas to help us know what is important to you/how best to support you.

|  |
| --- |
| **Please describe your / the person’s family life and family relationships.** |
|  |

|  |
| --- |
| **Please provide a brief educational and learning history.** |
|  |

|  |
| --- |
| **Please provide a description of your / the person’s, likes, dislikes, wants, wishes and aspirations** |
|  |

|  |
| --- |
| **What social, leisure and recreation interests do you/does the person enjoy?** |
|  |

|  |
| --- |
| **Do you / does the person express feelings and behave in a way which would be verbally or physically threatening to other people?** |
|  |

|  |
| --- |
| **Do you / does the person display any behaviour requiring specialist intervention?  If yes, what support networks/strategies are currently in place?** |
|  |

|  |
| --- |
| **How do you/ does the person communicate?**  **Detail any specialist support/equipment required.** |
|  |

|  |
| --- |
| **Do you/does the person have any specific dietary requirements or eating disorders?** |
|  |

|  |
| --- |
| **Do you/does the person suffer from any allergies?** |
|  |

**Please provide a brief medical history.**

|  |  |
| --- | --- |
| **Current GP Name:** | **Contact Number:** |
|  |  |
| **Address:** | |
|  | |

|  |  |
| --- | --- |
| **Current Dentist Name:** | **Contact Number:** |
|  |  |
| **Address:** | |
|  | |

|  |  |
| --- | --- |
| **Current Care Manager:** | **Contact Number:** |
|  |  |
| **Address:** | |
|  | |

|  |
| --- |
| **General Medical History include any diagnosed medical condition or syndrome** |
|  |

**Mobility Needs**

|  |  |  |
| --- | --- | --- |
|  | **At home** | **In Community** |
| **Able to walk unaided** |  |  |
| **Able to walk with assistance** |  |  |
| **Uses a manual wheelchair** |  |  |
| **uses an electric wheelchair** |  |  |

If you/the person is attending school or college please provide the following information (on the next page) about their educational programme.

If you/ the person participates in day time activities please provide a description of the service.

|  |
| --- |
| **Contact Details:** |
|  |
| **Timetable:** |
|  |

|  |
| --- |
| **Do you/does the person attend a day centre/separate day provision?**  **If yes, please detail activities.**  **If no, detail any meaningful activities undertaken each week** |
|  |

|  |  |
| --- | --- |
| **Do you / does the person require any specialist clinical treatment?** | **Yes / No** |

|  |
| --- |
| **Details:** |
|  |

|  |
| --- |
| **Do you/does the person currently require specialist equipment? If yes, list below and detail arrangements for ownership, supply, maintenance and replacement.** |
|  |

|  |  |
| --- | --- |
| **Do you / does the person have any support needs in the following area:** | |
| Incontinent (faeces) - Day |  |
| Incontinent (faeces) - Night |  |
| Incontinent (urine) - Day |  |
| Incontinent (urine) - Night |  |

|  |
| --- |
| **Detail specialist intervention and arrangements** |
|  |

|  |
| --- |
| **Do you / does the person have epilepsy?**  **(If yes please Detail specialist intervention and arrangements)** |
|  |

|  |  |
| --- | --- |
| **Do you / does the person have any visual impairment?** If yes, please give details and points of contacts in the box provided | **Yes / No** |
|  | |

|  |  |
| --- | --- |
| **Do you / does the person have any hearing loss?** If yes, please give details and points of contacts in the box provided | **Yes / No** |
|  | |

|  |
| --- |
| **We would like to know what type of service you, your advocate, family members and/or professional carers envisage being provided.** |
|  |

**Do you/does the person have:**

|  |  |
| --- | --- |
| **Next of Kin** If yes, please provide Name, Relationship and Contact Tel Number: | **Yes / No** |
|  | |

|  |  |
| --- | --- |
| **Advocate** If yes, please provide Name and Contact Tel Number: | **Yes / No** |
|  | |

|  |  |
| --- | --- |
| **LPA: Financial Property  Continuing Power of Attorney (in Scotland)** If yes, please provide Name and Contact Tel Number: | **Yes / No** |
|  | |

|  |  |
| --- | --- |
| **LPA: Welfare Continuing Power of Attorney (in Scotland)** If yes, please provide Name and Contact Tel Number: | **Yes / No** |
|  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you/does the person have any prescribed medication?**  If yes, please list below | | | | **Yes / No** |
| **Name** | **Dose** | **Time** | **Reason for medication** | **Px’d by** |
|  |  |  |  |  |

|  |
| --- |
| **Do you/does the person self medicate? Refer to Medication policy** |
|  |

|  |
| --- |
| **Is there a current risk assessment in place?** |
|  |

|  |  |
| --- | --- |
| Name |  |
| Signature |  |
| Date |  |

**Are there are further specialist information or assessments available to provide additional needs information regarding the person?**

|  |  |
| --- | --- |
| **Psychiatric Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Neuro-psychological Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Behavioural Psychological Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Behavioural Management Protocols** | **Yes / No** |

|  |  |
| --- | --- |
| **Educational Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Physiotherapy Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Sensory Impairment Report (Speech etc).** Please indicate | **Yes / No** |

|  |  |
| --- | --- |
| **Occupational Therapy Report** | **Yes / No** |

|  |  |
| --- | --- |
| **Person-Centred Planning** | **Yes / No** |

|  |  |
| --- | --- |
| **Current Support Plan** | **Yes / No** |

|  |  |
| --- | --- |
| **Life History** | **Yes / No** |

|  |  |
| --- | --- |
| **Risk Assessments** | **Yes / No** |

|  |  |
| --- | --- |
| **Any Other** | **Yes / No** |