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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | | | | | | | | | |
| CLIENT NAME | | |  | | | | | DATE OF BIRTH | | | | | | |  | |
| MALE/FEMALE | | |  | | | | | MARITAL STATUS | | | | | | |  | |
| NHS NUMBER | | |  | | | | | SOCIAL SERVICES ID NO | | | | | | |  | |
| SECTION | | |  | | | | |  | | | | | | |  | |
| LAST KNOWN HOME | | |  | | | | | LEARNING DISABILITY | | | | | | |  | |
| ADDRESS | | |  | | | | | 1ST LANGUAGE | | | | | | |  | |
|  | | | | | | | | | | | | | | | | |
| **CURRENT DIAGNOSIS AND BACKGROUND INFORMATION (Please attach any supporting documentation)** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL (Please list any requirements )** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **CURRENT PLACEMENT** | | | | | | | | | | | | | | | | |
| HOSPITAL/HOME NAME | | | |  | | | | | WARD | |  | | | | | |
| CONTACT NAME | | | |  | | | | | ADDRESS | |  | | | | | |
| MANAGER | | | |  | | | | | TELEPHONE/EMAIL | |  | | | | | |
| **GP DETAILS** | | | | | | | | | | | | | | | | |
| **CURRENT GP NAME** | | | |  | | | | | CONTACT NO | | | |  | | | |
| **ADDRESS** | | | |  | | | | | EMAIL | | | |  | | | |
|  | | | |  | | | | |  | | | |  | | | |
|  | | | | | | | | | | | | | | | | |
| **REFERRAL MADE BY** | | | | | | | | | | | | | | | | |
| NAME |  | | | | | | | | JOB TITLE | |  | | | | | |
| ORGANISATION |  | | | | | | | | TELEPHONE | |  | | | | | |
| ADDRESS |  | | | | | | | | POSTCODE | |  | | | | | |
| DATE OF REFERRAL |  | | | | | | | | EMAIL | |  | | | | | |
|  | | | | | | | | | | | | | | | | |
| **FUNDING AUTHORITY** | | | | | | | | | | | | | | | | |
| ORGANISATION | |  | | | | | | | TELEPHONE | | |  | | | | |
| NAME | |  | | | | | | | JOB TITLE | | |  | | | | |
| ADDRESS | |  | | | | | | | EMAIL | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| **PROFESSIONALS INVOLVED IN CLIENT’S CARE** | | | | | | | | | | | | | | | | |
|  | | NAME | | | | ORGANISATION | ADDRESS | | | EMAIL | | | | | | CONTACT NUMBER |
| CLINICAL LEAD | |  | | | |  |  | | |  | | | | | |  |
| SOCIAL WORKER | |  | | | |  |  | | |  | | | | | |  |
| CPN | |  | | | |  |  | | |  | | | | | |  |
| OTHER | |  | | | |  |  | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | |
| **NEXT OF KIN** | | | | | | | | | | | | | | | | |
| CONTACT NAME | |  | | | | | | | TELEPHONE | | |  | | | | |
| ADDRESS | |  | | | | | | | EMAIL | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| **CURRENT RISK FACTORS** | | | | | | | | | | | | | | | | |
| Physical Aggression History | | | | |  | | | | Absconding | | | | |  | | |
| Arson | | | | |  | | | | Suicide | | | | |  | | |
| Self-harm | | | | |  | | | | Self-neglect | | | | |  | | |
| Drug Abuse | | | | |  | | | | Alcohol Abuse | | | | |  | | |
| Forensic History | | | | |  | | | | Physical Disabilities | | | | |  | | |
|  | | | | |  | | | |  | | | | |  | | |
|  | | | | | | | | | | | | | | | | |
| **THANK YOU FOR YOUR REFERRAL** | | | | | | | | | | | | | | | | |

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What happens next?**

A clinical assessment will be arranged with the client’s current placement.

Our Clinical Assessor will meet with the client, staff and clinicians and review the client’s notes.

It would be helpful if we could have access to any of the following information

* **Psychiatric reports**
* **Risk assessments**
* **Care plan**
* **CPA notes**
* **CHC reports**

If appropriate, we will arrange for the client to visit the service. We will provide a Support and Risk Mitigation Plan.

Please email this form back to **referrals@rehabilityuk.co.uk**

**HEAD OFFICE:**

Kingston House, 438-450 High Street, West Bromwich B70 9LD Tel: 03333 44 3095

[www.rehabilityuk.co.uk](http://www.rehabilityuk.co.uk/)