REFFERAL FORM

Please note that all referrals will need appropriate risk assessments

This will need to be the most recent.

REFERAL TO AMETHYST HEALTHCARE

Hill Stone House
59 Colcot Road
Barry
CF62 8HL

PLEASE SPECIFY when you want the support to start:

TITLE (PLEASE DELETE AS APPROPIATE):

MR/MRS/MISS

OTHER (PLEASE SPECIFY)

FORENAME

SURNAME

DATE OF BIRTH

LANGUAGE (PLEASE SPECIFY FIRST LANGUAGE SPOKEN):

Please indicate if you have any communication needs? For example nreed of a translation service?

Current Address:

CONTACT TELEPHONE NUMBER:

MOBILE:

LANDLINE:

N.I NUMBER :

DOES THE CLIENT HAVE AN APPOINTEE (PLEASE TICK APPROPIATE BOX) Yes/No

PLEASE GIVE DETAILS OF APPOINTEE AND PLEASE INCLUDE THE RELATIONSHIP OF THE APPOINTEE TO THE CLIENT IN RECIEPT OF REFERRAL

HAS THE CLIENT USED AMETHYST HEATHCARE SERVICES BEFORE (PLEASE TICK APPROPIATE BOX) **Yes/No.**

If 'yes' please specify:

REFERRED BY:

POSITION:

AGENCY:

E-MAIL:

LANDLINE NUMBER:

MOBILE NUMBER:

PLEASE SPECIFY WHY YOU ARE REFERRING THE CLIENT (PLEASE INCLUDE RELEVANT HISTORY AND WHAT THE CLIENTS PRESENTING NEEDS ARE)

PLEASE SPECIFY IF CLIENT NEEDS THEIR SUPPORT TO START ON A SPECIFIC DAY:

PLEASE LIST MEDICATION THAT IS TAKEN BY THE CLIENT AND PREFERRED METHOD OF TAKING MEDICATION. ALSO GENERAL HEALTH, PHYSICAL HEALTH AND ALSO WHETHER THE PERSON LIVES WITH ANY DISABILITY?

PLEASE STATE IF THE REFERRED PERSON MANAGES THEIR OWN FINANCES:

PLEASE STATE IF THERE IS A HISTORY OF SUBSTANCE USE:

PLEASE STATE IF THE PERSON IS SUBJECT TO ANY RESTRICTIONS, FOR EXAMPLE PROBATION/DOLS:

HAS THE CLIENT HAD ANY PREVIOUS INVOLVEMENT FROM MENTAL HEALTH OR LEARNING DISABILITY TEAMS - Yes/No

IF YES PLEASE GIVE DETAILS:

NEXT OF KIN CONTACT DETAILS (PLEASE PROVIDE, FULL NAME, ADDRESS, CONTACT PHONE NUMBER AND PLEASE SPECIFY THE RELATIONSHIP BETWEEN NEXT OF KIN AND THE CLIENT)

EQUAL OPPORTUNITIES

AMETHYST HEALTHCARE BELIEVES IN ACTIVELY PROMOTING EQUALITY OF OPPORTUNITY. PLEASE HELP US TO MONITOR THE EFFECTIVNESS OF OUR EQUAL OPPERTUNITIES POLICY, IDENTIFY AND CHALENGE DISCRIMINATION, AND PROMOTE DIVERSTY COMPLETING THIS FORM.

Gender:

Male	
Female	
Transgender	
Do not wish to state	

Sexual Orientation:

Bisexual	
Heterosexual	
Gay/Lesbian	
Do not wish To state	

Age

18-25	
26-35	
46-55	
56 and over	

Ethnicity:

White		**Black or Black British**	
English		African	
Irish		Caribbean	
Other (please describe)		Other (please describe)	
Asian or Asian British		**Mixed (dual heritage)**	
Indian		Asian & white	
Pakistani		Black African & white	
Bangladeshi		Black Caribbean &white	
Chinese		Other (please describe)	
Other (please describe)			

Religion/Belief

None		Muslim	
Christian		Buddhist	
Hindu		Atheist	
Jewish		Other (please specify)	
Sikh			

RISK ASSESMENT	HISTORICAL RISKS	CURRENT RISK (KEY ABOVE)
	Yes/No	ACTUAL/ HIGH/ MEDIUM /LOW
SUICIDAL ACTS/ IDEATION		
DELIBERATE SELF – HARM		
VIOLENCE/ HARM TO OTHERS		
SEXUALISED/ SEXUALLY HARMFUL BEHAVIOURS		
ARSON		
EATING DISORDER		
SUBSTANCE MISUSE		
NEGLECT/POOR SELF-CARE		
VULNERABILITY TO ABUSE/EXPLOITATION		
OTHER		

RISK ASSESMENT

KEY TO RISK ASSESMENT:

ACTUAL: KNOWN OR DISCLOSED OCCURENCES OR EXISTENCE OF RISK

HIGH: DISCLOSED INTENTIONS OR FREQUENT THOUGHTS OF RISK

MEDIUM: RISK PRESENT HISTORICALLY, BUT STABLE (NO THOUGHTS OT INTENTIONS SURROUNDING RISK)

LOW: NO HISTORICAL RISK, NO THOUGHTS OR INTENTIONS SURROUNDING RISK

OR UNKNOWN

SUMMARY OF RISK FACTORS (E.G. WHAT, WHEN, WHERE, HOW OFTEN, CAUSE FOR CONCERN REGARDING RISK?) Please give details below:

Activities of Daily Living

Please indicate what support is required to ensure a transition to independence and minimise risk.

This will form the basis of a support plan.

ACTIVITIES	INTEREST			ABLE TO COMPLETE TASK INDEPENDENTLY
	STRONG	SOME	NONE	YES/NO
Personal Activities				
Bathing				
Showering				
Washing Your Hair				
Shaving				
Nail Care				
Clothing				
Dressing/Undressing				
Personal Presentation				
Domestic Activities				
Washing Up				
Laundry				
Ironing				
Making/Changing the Bed				
Dusting				
Hoovering				
Emptying Daily Bins				
Mopping Floors				
Cleaning Bathroom				
Instrumental Activities				
Food Shopping				
Meal Planning and Preparation				
Cooking				
Taking Medication				
Paying Bills (Gas, Electric, Water, Telephone)				
Managing a Bank Account				
Registering on Electoral Role				
Voting				
Arranging Transport (Bus, Taxi)				

DISCLOSURE

WE ARE REQUIRED BY THE DATA PROTECTION ACT 2003 TO HAVE THE CLIENTS CONSENT FOR US TO 1) REQUEST INFORMATION FROM OR SHARE INFORMATION WITH OTHER SERVICES. 2) KEEP A RECORD OF THEIR SUPPORT FROM AMETHYST HEALTHCARE. ALL INFORMATION WILL BE DEALT WITH AS PER AMETHYST HEALTHCARES DATA PROTECTION & CONFIDENTIAL POLCIY.

I CONFIRM THAT THE CLIENT HAS AGREED TO THIS INFORMATION BEING PASSED TO AMETHYST HEALTHCARE. THE CLIENT UNDERSTANDS THE INFORMATION BE MAY BE PASSED TO OTHER AGENCIES

PLEASE TICK THE BOX TO CONSENT TO THE ABOVE ☐

Client Signature:	Date:
Referrer Signature:	Date:

WHERE THIS FORM SHOULD BE SENT

Please E mail completed referral forms to: office@ahcare.co.uk
IF YOU HAVE ANY ENQUIRIES, PLEASE CALL US ON 01446 742281