Mead House Day Academy Referral Form

SECTION A: DETAILS OF THE PERSON REFERRING THE PARTICIPANT

REFERRER DETAILS		
Name of Referrer		
Position		
Borough		
Organisation/Department		
Phone Number		
Email		
Document Attached (please name the documents you have attached with this referral form)		
Reason for referral		

SECTION B: PARTICIPANT INFORMATION *(please type of write clearly in black ink)*

PERSONAL DETAILS	
Name of Participant (first name & surname)	
Date of Birth (day/month/year)	
Gender	
Address	
Accommodation Type	
Contact Number (*Landline/mobile*)	
Email	

MEDICAL INFORMATION	
National Health Service (NHS) Number	
Name of Doctor	
GP Address	
GP email address	
Contact Number (*Landline/mobile*)	

SECTION C: PARTICIPANT'S FINANCIAL INFORMATION

BENEFIT INFORMATION				
National Insurance Number				
What benefit(s) are you currently receiving or have applied for?	**ESA** ☐	**PIP** ☐	**UC** ☐	**OTHER** ☐
	Yes ☐	Yes ☐	Yes ☐	Yes ☐
(Please disclose benefits you are currently receiving)	No ☐	No ☐	No ☐	No ☐
Funding Authority details:				

EMERGENCY CONTACT DETAILS	
Name of next of Kin	
Address	
Contact Number (*Landline/mobile*)	
Email Address	

ADULT SOCIAL CARE INFORMATION	
Is the person currently in receipt of care? -If yes, please attach a copy of their care act assessment and support plan	
Name of Social Worker or Care Manager	
Local Authority, County Council or Borough	
Contact Number (*Landline/mobile*)	
Email Address	

HEALTH INFORMATION			
Current Diagnosis or Diagnoses	**If answering yes to any question, please give as much detail as possible.**		
Physical Disability or other illness affecting mobility	Y ☐	N ☐	
Learning Disability	Y ☐	N ☐	
Mental Health Disorder	Y ☐	N ☐	
Addiction(s)	Y ☐	N ☐	
Hearing Impairment	Y ☐	N ☐	
Speech Impairment	Y ☐	N ☐	
Visual Impairment	Y ☐	N ☐	
Any allergies	Y ☐	N ☐	
Any food allergies	Y ☐	N ☐	

FOOD AND DRINK SUPPORT	
Liked Foods	
Disliked Foods:	
Is support required with eating and drinking? If yes, please give more details	
Does the person follow a cultural or religious diet? If yes, please give details	

Autistic Spectrum Condition	Y ☐	N ☐					
Complex Needs	Y ☐	N ☐					
Challenging Behaviours or behaviours of concern: Please give details of slow/fast triggers and de-escalation techniques used.	Y ☐	N ☐					
Do they have a Positive Behaviours Support Plan? -If so please attach a copy.	Y ☐	N ☐					
Assessed Level of Need (Group compatibility)	Mild (1:4)	☐	Moderate (1:2)	☐	Severe (1:1)	☐	

Other Information	
Methods of Support	
Summary of Risks	

INTERESTS AND EMPLOYMENT OPPORTUNITIES			
Does the participant have any special, or leisure interests?			
Identified employment opportunities	(*please tick which of the projects the participant would be interested in. If other state here*)		
Shredding and Digitization ☐	Cake Making & Sugar Craft ☐	Peer Support Worker ☐	Other (please state below) ☐

CONFIRMATION OF REFERRAL		
Reliant Care offers a confidential service; no details will be shared with third parties without the individual's prior consent.		
Signature of referrer and date of referral	*(Signature)*	Date

PLEASE RETURN TO:

Kofi Kyei-Mensah-Osei
Manager
Email: kofi162@reliantcare.co.uk
Mobile: 07727 606 467

Declaration: Reliant Care wishes to make it clear that it will not knowingly support the employment of disabled and, or vulnerable people within its own, or other supported employment projects, for unethical reasons, including financial and economical abuse.