REFERRAL FORM

Client Details			
Surname:		Forenames:	
Date of Birth:		Ethnicity:	
Legal Status: (informal/detained)		Marital Status:	
Name & Address of Spouse/Partner:			
Name & Address of Next of Kin:			
Family Situation and Involvement:			
Names and Dates of other previous placements:			
Legal Factors – Solicitors Name, Address and Telephone Number:			

Referrer Details		
Name:		
Designation:		
Organisation:		
Address: Postcode:		
Telephone:		Fax:
Email:		

Current Placement Details		
Organisation:		
Address: Postcode:		
Telephone:		Fax:
Email:		

GP Details		
Name:		
Practice Name:		
Address: Postcode:		
Telephone:		Fax:
Email:		
Who is the Client's DOL Supervisory Body?		
(name, address & contact number)		

Client History	
Details of Condition	
Medical History (including pre-existing conditions and mental health)	
Forensic History / Community Orders / Restrictions	
Social History (please give details of schooling, work history and relationships)	
Current Medication	

Living Skills

Continence	**YES / NO**	**Please give details including staff required.**
Independent?		
Urinary Incontinence		
Faecal incontinence		
Eating and Drink	**YES / NO**	**Please give details including staff required.**
Fully independent		
Requires assistance (e.g. aids, 1:1 staff)		
Any other needs (e.g. dietary, PEG, dysphagia)		
Personal Care	**YES / NO**	**Please give details including staff required.**
Fully independent?		
Requires assistance?		
Mobility	**YES / NO**	**Please give details including staff required.**
Fully independent?		
Requires assistance? (including wheelchair, hoist or any other equipment and numbers of staff required to assist)		
Sensory Skills	**YES / NO**	**Please give details including staff required.**
Hearing		
Vision		
Communication		

Levels of Aggression / Frequency	Daily	Weekly	Monthly (specify if over)
Verbal aggression			
Physical aggression against objects			
Physical aggression against self			
Physical aggression against others			

Risk Behaviours	Please describe
Wandering / absconsion	
Intimidation / bullying	
Arson	
Suicide / self harm	
Vulnerability	
Sexual Dis-inhibition	
Alcohol / substance misuse	

Memory / Cognitive Abilities
Mental Capacity – Has this been assessed?
Resident expectations / wishes if admitted to RPC
Any other relevant information **(please include any other relevant areas of difficulty and details of family involvement in current care/contact)**

Addition Contact Information	Name	Telephone Number
Consultant / RMO		
Care Co-Ordinator / Named Nurse		
Advocate		
Social Worker		
Solicitor		

Responsible Purchaser Contact Details	
Name	
Designation	
Address Postcode	
Telephone Number	
Is the purchaser aware of this referral?	
Funding Agreed	YES / NO

How did you hear of RPC?

Referral Form completed by:

Name:		**Position:**	
Address:			
Telephone No:		**Date Completed:**	