Grace
Recreational
Day Services

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.com

REFERRAL FORM

1)
DATE OF ASSESSMENT……..

NAME OF CLIENT……..

LIKES TO BE CALLED……..

DATE OF BIRTH……

MALE/FEMALE……

ADDRESS……

……..

ETHNIC ORIGIN……

RELIGION……..

2)
NEXT OF KIN……

ADDRESS……

TEL:……Email:……

2b)
CARER:……..

ADDRESS:……

TEL NO:…… EMAIL:……..

2c)
GP……

ADDRESS……..

TEL:……

DIAGNOSIS……..

MEDICATION……..

3)
TYPE OF REFERRAL: {Please tick as appropriate}

☐ Self-Referral ☐ Local Authority ☐ Other

REFERRER:……..

ADDRESS:……..

TEL:……

EMAIL:……

POSITION:……

REVIEW DATE:……..

OTHER INFORMATION:……..

4)

GENERAL HEALTH:……

MOBILITY:……

MOBILITY AID USED:……

EYE SIGHT:……..

GLASSES WORN……..

HEARING……

HEARING AIDS WORN……..

SPECIFY DISABILITY:……..

LEARNING DISABILITY: {Please tick as appropriate}

MILD ☐
-Basic reading/writing
-Care for self
-Able to hold conversation
-Able to get around independently

MODERATE ☐
-Basic words/gestures to communicate
-Ability to do own care needs
-High support level

COMMUNICATION/ RELATIONSHIPS	YES	NO
COMMUNICATES VERBALLY		
KNOWS MAKATON		
LIKES TO BE ALONE		
LIKES TO JOIN GROUPS		
CAN CALL FOR HELP IN DANGER		

OTHER RELEVANT INFORMATION:……..

……..

INDEPENDENCE	UNAIDED	SOME SUPPORT	TOTAL SUPPORT
GO OUT WALKING LOCALLY			
USE BUSES			
USE TRAINS/ UNDERGROUND			
GO TO LOCAL SHOPS			
USE MONEY			
UNDERSTANDS VALUE OF MONEY			
TELLS THE TIME			
KNOWS DAYS OF THE WEEK			
KNOWS MONTHS OF THE YEAR			
CAN READ			
CAN WRITE			
MAKES SNACKS			
MAKES HOT DRINKS			
WASHES DISHES			

5)

Challenges Behaviours	Triggers	Intervention/support
1.		
2.		
3.		

6**)**
HOBBIES/INTERESTS:……

……

……

Likes:	Dislikes:

7)
OTHER REVELANT INFORMATION:

8)
REPORT COMPLETED BY:……..

KEYWORKER:……

MANAGER:……..

ASSESSMENT COMPLIATION DATE:……..

ASSESSMENT CARRIED OUT BY:……..