**Referral**



**Aiding Independence Ltd**

**Referral Form**

|  |
| --- |
| Client Name –Address –Tel - D.O.B –Gender –Ethnicity – Religion – |

|  |
| --- |
| Communication used – |

|  |
| --- |
| Referral received from –Care Manager Name –Address and contact details of Care Manager – |

|  |
| --- |
| Support Required – Days required –Number of hours required –Time and place of support -Specific support needs – |

|  |
| --- |
| Communication Needs – |

|  |
| --- |
| Medical conditions known – |

|  |
| --- |
| Mobility Information – |

|  |
| --- |
| Risks outlined by Care Manager or family –Completed by –Date - |



Aiding Independence

18 High Street

Herne Bay

Kent

CT6 1LH

Assessment Form

|  |  |  |
| --- | --- | --- |
| 1 | Name of Client |  |
| 2 | Home Address |  |
| 3 | D.O.B |  |
| 4 | Next of Kin Details |  |
| 5 | National Insurance Number |  |
| 6 | NHS Number |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 7 | Referral FromCare Manager/Family |  | Care ManagerContact/Address |  |
| 8 | Date of Assessment |  |  Location of Assessment |  |

|  |  |  |
| --- | --- | --- |
| 9 | Name of Person carrying out Assessment |  |
| 10 | Present at Assessment |  |
| 11 | Medical Conditions/ Diagnosis |  |
| 12 | Current Medication  |  |
| 13 | Self Medicating | YES NO |
| 14 | Help Needed with Medication |  |

|  |  |  |
| --- | --- | --- |
| 15 | G.P Contact Information |  |
| 16 | Current Specialist Involved i.e. phycologist/ Speech therapist |  |

|  |  |  |
| --- | --- | --- |
| 17 | Mobility Information |  |
| 18 | Travel AbilityBus PassTrain TravelDriver |  |

|  |  |  |
| --- | --- | --- |
| 19 | Communication Used/Preferred |  |

|  |  |
| --- | --- |
| 20 |  |
| Weekly Plan incl. any Service Provision/ Work |  |
| Mon |  |
| Tue |  |
| Weds |  |
| Thurs |  |
| Fri |  |
| Sat |  |
| Sun |  |
| 21 | Things I like and things that make me happyHobbies/Interests |  |
| 22 | Things I Dislike and make me upset |  |
| 23 | People that are important to me |  |
| 24 | Risk Outlined/Identified |  |

|  |  |  |
| --- | --- | --- |
| 25 | Support Type Required  |  |
| 26 | Number of Hours Required |  |
| 27 | Time and Place of Support |  |

|  |  |  |
| --- | --- | --- |
| 28 | Current Benefits |  |
| 29 | Managing Money & Skills/Understanding |  |

|  |  |  |
| --- | --- | --- |
| 30 | Religious Beliefs/Needs |  |
| 31 | Support Start Date …..Forward Plan…Handbook Given….. |  |