

**Referral Form for Service Users**

**Which services are you interested in (tick all that apply):**

|  |  |  |
| --- | --- | --- |
| [ ]  **Adult Services (19-65 yrs)** | [ ]  **Other** (please specify): |  |
| (The Camberwell Incredibles)  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |  |  |
| **Days interested in:** |  |  |  |
| [ ]  Mondays | [ ]  Tuesdays | [ ]  Wednesdays | [ ]  Thursdays | [ ]  Fridays |
|   |

**Service User Information**

|  |
| --- |
| Name of Service User:  |
| Address:  |
| Postcode:  |
| Telephone number:  |
| Date of birth:  |
| School/college attending (if relevant):  |
| **Financial information** (for adult services only)Is the Service User on a personal budget: Yes [ ]  No [ ] **Personal Budget Invoice details**Contact name: Contact email: Contact phone number:  |

**Parent/Carer Contact Details**

|  |  |
| --- | --- |
| **Name of Parent/Carer 1** |  |
| Telephone number |  |
| Mobile number |  |
| **Name of Parent/Carer 2** |  |
| Telephone number |  |
| Mobile number |  |

**Emergency Contacts**

|  |  |
| --- | --- |
| 1st Emergency contact name |  |
| Address |  |
| Telephone number |  |
| 2nd Emergency contact name |  |
| Address |  |
| Telephone number |  |

**Social Worker/Advocate**

|  |  |
| --- | --- |
| Social Worker/Advocate name |  |
| Social Worker email |  |
| Social Worker telephone number |  |

**Medical Information**

|  |  |
| --- | --- |
| **My disability/medical condition is (Please state):** |  |

**Information on my condition** (Please include details about behavioural and support needs):

**Allergies**

Please state any known allergies:

**Dietary Needs**

Please state dietary requirements.

|  |  |
| --- | --- |
| Dairy free |   |
| Gluten free |  |
| Wheat free |  |
| Shell fish allergy |  |
| Peanut allergy |  |
| Vegetarian |  |
| Vegan |  |
| No pork |  |
| No red meat |  |
| Please list any other food/drink not listed |  |

**Specialised Equipment for Service User**

|  |  |  |
| --- | --- | --- |
| Equipment | Yes | No |
| Do you use a wheelchair? |  |  |
| Do you require wheelchair clamps on the bus? |  |  |
| Do you require a bucket seat on the bus? |  |  |
| Do you wear a body brace? |  |  |
| Do you wear a helmet? |  |  |
| Do you wear a hearing aid? |  |  |
| Do you wear glasses? |  |  |
| Do you wear a leg brace? |  |  |
| Other equipment not listed? |  |

**Communication**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Additional comments |
| I can speak |  |  |  |
| I can hear |  |  |  |
| I can understand when spoken to |  |  |  |
| I can show you what I want by pointing |  |  |  |
| I use Makaton |  |  |  |
| I use Pecs |  |  |  |
| Other |  |  |  |

**Personal Care Needs**

|  |  |  |  |
| --- | --- | --- | --- |
|  | On my own | With help | No, I’m unable to do this |
| Wash |  |  |  |
| Dress |  |  |  |
| Feed |  |  |  |
| Stairs |  |  |  |
| Walk |  |  |  |
| Handle money |  |  |  |
| Use the toilet |  |  |  |

**Toileting**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| I am incontinent |  |  |
| I wear pads/nappies |  |  |
| Other support needs |  |  |

**Additional Information**

Please give any extra information about the Service User (e.g. Likes/dislikes; previous experience of related activities; areas of particular interest; anxieties/triggers; warning signs; coping mechanisms; risk factors; etc.).

**Activity Consent**

|  |  |
| --- | --- |
| **I give consent (please tick):**  |  |
| [ ]  For the Service User to attend and take part in all activities as stated on the timetable. |  |
| [ ]  For Cambridge House to keep a record of this information for health and safety and monitoring purposes. |  |
| [ ]  For the Service User to be transported by minibus/cab/train/bus to and from Cambridge House including outings (where necessary). |
| [ ]  For the senior worker to administer **prescribed medication from a G.P** that is in its original container (where necessary). |
| [ ]  That in the unlikely event of the Service User being involved in an accident and being taken |
| to hospital **I give consent** for appropriate treatment to be given.  |  |
| [ ]  For sun cream to be applied where appropriate.  |  |
|  |  |
| **Is the Service User currently taking prescribed medication that needs to be administered during the hours they will be in our care?** Yes [ ]  No [ ]  |
|   |
| If **yes**, please fill in the section “**Parent / Carer agreement for staff to administer medicine**” (below page 7) |
| **Media Consent** In order to showcase our services and celebrate the work of our groups, Cambridge House regularly gathers photos, videos and audio content at our sessions and events. These may be used on our website, social media, promotional materials, publications, funder reports, press releases or other illustrations of our work. We will always ask our group members whether they are happy for photos of them to be taken and used, and **these can be removed on request at any time**.  |
| Our strict policy on the use of any photo, video and audio content commits us to:* Never revealing any personal details of individuals being photographed/filmed/audio recorded.
* Only using the photos/video/audio content as indicated above.
* Storing any photo/video/audio content securely in password-protected folders and ceasing to use them for new promotional purposes immediately at the request of the individual.
* Not sharing the photo/video/audio content with third parties, except our event partners (including funders).
 |
| You are able to: * Withdraw your consent at any time by contacting data@ch1889.org or writing to us at the address below. If you withdraw your consent, we will stop using the photos/videos/audio content for future purposes but may not be able to retract publications already in the public domain.
* Ask us to erase the photos, video or audio content. As indicated above, we may not be able to retract publications already in the public domain.
* Contact us if you have any questions or complaints. Alternatively, you may complain to the Information Commissioners Office via their helpline on 0303 123 1113.
* Ask us for a copy of the photos, video or audio content that we store in relation to the Service User.
 |
| **I give permission to be (please tick):**Photographed [ ]  Filmed [ ]  Audio Recorded [ ]  |
| **Data Protection** Cambridge House is committed to making sure your privacy is protected. We will only collect the information we require to effectively carry out our services, to ensure the health and safety of our service users, to keep you informed about our work, relevant opportunities and events, and for required reporting. A full copy of our Data Protection, Privacy and Confidentiality Policy is available on request. |
| **I understand that I can withdraw my consent at any time by contacting** **data@ch1889.org** **or by writing to us at Unit F, Ground Floor, The Print Works, 22 Amelia Street London SE17 3PY.**[ ] (please tick as appropriate) |  |
|  |  |
| **I give my permission for Cambridge House to maintain a record of my case** [ ]  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
| **Signature:** |  |  |  |

**Parental Consent**

If the individual is under 18 years of age or is not able to complete this form themselves, their parent, legal guardian or authorised legal representative must sign below:

I confirm that I am the parent, legal guardian or authorised legal representative of this individual and warrant that I have lawful authority to sign this consent form for and on their behalf.

**Your Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of service user:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(if signing on their behalf)**

**Date of Birth of service user:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your contact number for enquiries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Service User:**

Parent [ ]

Guardian [ ]

Authorised Legal Representative [ ]

|  |
| --- |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Parent / Carer Agreement for Staff to Administer Medication**

We **will not** give the Service User prescribed medicine unless you complete and sign this section.

Medical condition/illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Medicines must be the original container as dispensed by the pharmacy.**

**Medicine**

Name/Type of Medicine (as described on the container):

Date dispensed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiry date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage and method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Timing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Precautions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of tablets/quantity to be given to Project Leader:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any side effects that we need to know about?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self Administration: Yes/No *(delete as appropriate)*

**Procedures to take in an Emergency:**

**I understand that I must give the medicine personally to agreed member of staff and accept that this is a service that the staff are not obliged to undertake. The above information is, to the best of my knowledge, accurate at the time of writing and I give consent for staff to administer medicine as advised. I will inform the Group Leader and Head of Service immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Carer name (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Service User:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Equality and Diversity Monitoring (used for statistical purposes only)**

|  |
| --- |
| **Age:**[ ]  0-11 [ ]  26-34 [ ]  55-64 [ ]  85+[ ]  12-17 [ ]  35-44 [ ]  65-74 [ ]  18-25 [ ]  45-54 [ ]  75-84 |
| **Gender:**[ ] Male [ ]  Female [ ]  Transgender[ ] Other? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Sexual Orientation:**[ ]  Heterosexual/Straight [ ]  Gay/Lesbian [ ]  Bisexual[ ]  Other? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Ethnicity:** White –[ ]  British [ ]  Any other white background? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Black / African / Caribbean / Black British – [ ] British [ ]  Caribbean [ ]  African[ ]  Any other black background? Please specify: Mixed / Multiple ethnic groups – [ ]  White and Black Caribbean [ ]  White and Black African[ ]  White and Asian[ ]  Any other mixed/multiple ethnic background? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Asian / Asian British –[ ]  British [ ]  Indian [ ]  Pakistani[ ]  Bangladeshi [ ]  Chinese[ ]  Any other Asian background? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Ethnic Group –[ ]  Any other ethnic group? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Religion:**[ ]  No religion [ ]  Christian [ ]  Muslim [ ]  Jewish[ ] Hindu [ ]  Buddhist [ ]  Sikh[ ]  Any other religion? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Disability:**[ ]  Long-term health condition (Physical) [ ]  Long-term health condition (Neurological)[ ]  Physical Disability [ ]  Learning Disability[ ]  Sensory impairment [ ]  Autistic Spectrum Disorder[ ]  Dementia [ ]  Mental Health Condition[ ]  Multiple conditions[ ]  Other? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |