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| **logo4.bmp****The Pepper Pot Centre****REFFERAL FORM** | **The Pepper Pot Centre****1a Thorpe Close****Ladbroke Grove****London W10 5XL****Tel: 020 8968 6940****Fax: 020 8968 3169 www****.pepperpotcentre.org.uk** |

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| **SURNAME:** |  | **FIRST NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE NUMBER:** |  |
| **DATE OF BIRTH:** |  |
| **DO YOU LIVE ALONE:** | **YES □ NO □** ***(PLEASE TICK APPROPRIATE BOX)*** |

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| **NEXT OF KIN:** |  |
| **RELATIONSHIP:** |  |
| **ADDRESS:** |  |
| **TELEPHONE NUMBER:** |  |

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| **MEDICAL INFORMATION** |
| **NAME OF GP:** |  |
| **ADDRESS:** |  |
| **TELEPHONE NUMBER:** |  |
| **MEDICATION:** |  |
| **RELIVANT HEALTH ISSUES (PHYSICAL & PSYCHOLOGICAL):** |
| **SPECIAL NEEDS (DIET, LANGUAGE, AND CULTURE ETC.):** |

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| **FIRST LANGUAGE:** |  |
| **OTHER LANGUAGE SPOKEN:** |  |
| **DO YOU NEED AN INTERPRETER:** | **YES □ NO □** ***(PLEASE TICK APPROPRIATE BOX)*** |
| **ARE THERE ANY CULTURAL OR RELIGIOUS FACTORS TO CONSIDER?*****(IF YES, PLEASE GIVE DETAILS BELOW)*** | **YES □ NO □** ***(PLEASE TICK APPROPRIATE BOX)*** |
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| **DAILY LIVING ACTIVITIES: MOBILITY/GETTING AROUND – Please give details of any difficulties experienced in getting around, either at home or outside e.g. up & down stairs, using public/private transport, using or needing mobility aids. *(PLEASE GIVE DETAILS BELOW)*** |
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| **Are there any pieces of equipment that the client uses regularly? E.g. Wheelchair, Walking frames/sticks, Mobility scooter etc. *(IF YES, PLEASE GIVE DETAILS BELOW)*** | **YES □ NO □ *(PLEASE TICK APPROPRIATE BOX)*** |
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| **PERSONAL CARE: Please give details of assistance needed e.g. using the toilet, maintaining cleanliness (bathing & showering), cutting nails, shaving, skin & hair care, taking medication etc.  *(PLEASE GIVE DETAILS BELOW)*** |
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| **Continence & Incontinence Care: Continence - the individual has control of their bladder and bowel functions but needs help to maintain this control. Incontinence - involuntary loss of urine or faeces, which can significantly disrupt the quality of life of those affected. *(IF APPLICABLE, PLEASE GIVE DETAILS BELOW)*** |
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| **COMMUNICATION – Please specify needs, concerns or difficulties related to visual, speaking, hearing, reading, writing or communications generally. *(IF APPLICABLE, PLEASE GIVE DETAILS BELOW)*** |
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| **OTHER SERVICES REQUIRED – Please give details e.g. *Occupational therapy (OT), Community choice waiver (CCW)*** |
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| **CLIENTS VIEWS – How can we meet your needs?** |
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| **REASONS FOR REFFERAL – To be completed by the referrer.** |
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| **DAYS OF ATTENDANCE – Please tick boxes corresponding to the days you want the client to attend.** |
| **MONDAY □** | **TUESDAY □** | **WEDNESDAY □** | **THURSDAY □** | **FRIDAY □** | **SATURDAY □** | **SUNDAY □** |

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| **TRANSPORT – How will you travel to the centre? *(PLEASE TICK APPROPRIATE BOX)*** |
| **Public Transport □** | **Centre Transport □** | **Car/Taxi □** | **Walk □** | **Other □** |
| **If centre transport is required, please complete details of ACCESS section.** |

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| **ACCESS - PLEASE TICK APPROPRIATE BOX WHERE NECCERSARY AND GIVE ANY ADDITIONAL INFORMATION IF REQUIRED.** |

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| **Types of access at your premises?** | **External stairs □ Internal Stairs □ Lift □ Special access □** ***(PLEASE TICK APPROPRIATE BOX)*** |
| **PLEASE DESCRIBE ANY DIFFICULTIES THE CLIENT MAY HAVE IN EACH SITUATION.** |

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| **IS PARKING AVAILABLE?** | **YES □ NO □ *(PLEASE TICK APPROPRIATE BOX)*** |
| **IF YES, PLEASE GIVE DETAILS OF ANY RESTRICTIONS THAT MIGHT OCCUR. E.G. limited parking times, parking permits etc.** |

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| **IS THE CLIENT AWARE OF THIS REFERRAL?** | **YES □ NO □ *(PLEASE TICK APPROPRIATE BOX)*** |
| **NAME OF REFERRER:** |  |
| **DATE:** |  |

**Please turn the page for Information regarding the return of this referral.**

**Please return this form by post, fax or email to:**

**The Pepper Pot Centre**

**1a Thorpe Close**

**Ladbroke Grove**

**London W10 5XL**

**Tel: 020 8968 6940**

**Fax: 020 8968 3169**

**Email**: reception@pepperpotcentre.org.uk

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| **ADDITIONAL INFORMATION:** |
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| **FOR ADMINISTRATIVE USE** |
| **DATE RECEIVED:** |  |
| **APPLICANT TO ATTEND ON** |
| **MONDAY □** | **TUESDAY □** | **WEDNESDAY □** | **THURSDAY □** | **FRIDAY □** | **SATURDAY □** | **SUNDAY □** |
| **TRANSPORT:** |  |
| **DATE OF FIRST VISIT:**  |  |
| **ATTENDANCE COMMENCING ON:** |  |
| **APPROVED BY:** |  |
| **REVIEW DATE:** |  |