Referral Form

ONCE COMPLETED, PLEASE RETURN TO:
Gwenllian Education Centre,
Hillfield Villas,
Kidwelly,
Carmarthenshire,
SA17 4UL

Tel: 01554 890796
E-mail: info@gwenllianeducationcentre.co.uk

1. STUDENTS PERSONAL DETAILS

Surname:

First Names:

Present Address:

Telephone Number:

Age:

Date of Birth:

Gender:

Ethnic Origin:

Religion:

NHS Number:

Current Diagnosis:

Medication:

2. REFERRING AGENCY/PERSON

Referrer Name:

Designation:

Address:

Telephone Number:

E-mail address:

Involved Professionals/Agencies		Name	Contact Number
Psychiatrist	Yes / No		
Community Nurse	Yes / No		
Psychologist	Yes / No		
Occupational Therapist	Yes / No		
Social Worker	Yes / No		
Speech Therapist	Yes / No		
Careers/Connexions:	Yes / No		
Other (Please Specify)	Yes / No		

Name of person holding financial authority:

Designation:

Address:

Telephone number:

E-mail:

Has funding been agreed? Yes / No / In Principle

4. FAMILY CONTACTS

Details of next of kin/significant family member

i) Name:

Relationship:

Address:

Telephone number:

Mobile number:

E-mail:

ii) Name:

Relationship:

Address:

Telephone number:

Mobile number:

E-mail:

5. REASON FOR REFERRAL (please describe recent behaviours, if any, over past three months including frequencies and intensity)

PLEASE SUMMARISE IN SECTIONS 6-13 IN SPACE PROVIDED AND ATTACH RELEVANT REPORTS.

6. DEVELOPMENT HISTORY SUMMARY

7. SOCIAL AND FAMILY HISTORY SUMMARY

8. EDUCATIONAL SUMMARY

9. ADAPTIVE FUNCTIONING (SELF CARE, INDEPENDENCE/LIFE SKILLS)

10. MEDICAL INFORMATION

Does the client have any neurological or physical conditions or special needs, or any relevant prior medical condition, e.g. epilepsy

11. BEHAVIOURAL DIFFICULTIES

Does the student have any difficulties in the following areas (if so, please describe):-

Verbal Difficulties

Physical Disabilities

Sensory Difficulties

Incontinence

Behavioural Problems e.g. Aggression

Destruction of the Environment

Relationship Issues

12. RISK ASSESSMENTS (PLEASE ATTACH CURRENT RISK ASSESSMENTS IF AVAILABLE)

A) Current day time staffing ratios:

B) At home:

C) Out In the community:

D) At night:

13. NAME OF PERSON COMPLETING THIS FORM

Name:	
Designation:	
Address:	
Contact Telephone Number:	
E-mail Address:	