**Aspinden Care Home – Referral Form**

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| Aspinden Care Home 1 Aspinden Road London SE16 2DR  **Phone:** 020 7237 0331  **Email:** Enquiries.ACH@equinoxcare.org.uk **Web:** [www.equinoxcare.org.uk](file:///C:/Users/damian.callender/AppData/Local/Temp/246/Temp1_information%20(2).zip/information/www.equinoxcare.org.uk) |
| **1. Referral Agency:**  Referrers Name: Agency Name:  Address:    Post code: Email address:  Telephone No: Mobile No:  **How did you hear about the service?**  **………………………………………………………………………………………………………** |

**2. Client Details:**

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| Service User Name: | | | | | | | | | | | | | | |
| D.O.B | | Gender: | | | Marital Status: | | | | | Sexuality: | | | | NHS No: |
| Age: | | NI No: |
| **Current accommodation type**  Supported living ⬜ Hostel ⬜ NFA ⬜ Own tenancy ⬜ Other ⬜  Address:  Post code:  Telephone No: Mobile No: | | | | | | | | | | | | | | |
| Notice of admission date required: **……………………………………………………………..** | | | | | | | | | | | | | | |
| **Next of Kin name**:  Relationship:  Address:  Post code:  Telephone No: | | | | | | | | | | | | | | |
| **Benefits:**  Receipt of benefits: Yes⬜ No ⬜  Which benefit: ……………………………………………………………….  If not what other income is received: ………………………………………………. | | | | | | | | | | | | | | |
| **Ethnicity:**  White ⬜ Black ⬜ Mixed ⬜ Other ⬜  British ⬜ Irish ⬜ European ⬜ Caribbean ⬜  African ⬜ Asian ⬜ SE Asian ⬜ Other ⬜  Interpreter needed: Yes ⬜ No ⬜ If yes which language?  Religion: (specify spiritual needs)  Special dietary requirements: Yes ⬜ /No⬜Please state: | | | | | | | | | | | | | | |
| **GP Details:**  Surgery:  GP Name:  Address:  Post code:  Email address  Telephone No: | | | | | | | | | | | | | | |
| Please State Funding Borough:  Funding Agreed: Yes ⬜ No ⬜ Chain No: ……………………. | | | | | | | | | | | | | | |
| **Covid vaccination status** | | | | | | | | | | | | | | |
| Are you received 2 doses of covid vaccination Yes ⬜ No ⬜  If no, please comment:  Have you received the booster vaccination Yes ⬜ No ⬜  If no, please comment: | | | | | | | | | | | | | | |
| **4. Alcohol Misuse**  **Please ensure that all information given in this section is accurate and up to date.**  Drinking history:  How many units of alcohol do you consume in 24 hours?:  What type of alcohol do you consume?:  What attempts to change the above using behaviour has the service user made: | | | | | | | | | | | | | | |
| **5. Treatment history:** | | | | | | | | | | | | | | |
| Past treatment & detoxes: Please specify when and where most recent first | | | | | | | | | | | | | | |
| Date | Community | | | Inpatient | | | Rehab | | | | | Period of abstinence | | |
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| Please give a brief summary of support received after previous treatment episodes: | | | | | | | | | | | | | | |
| **6. Health** | | | | | | | | | | | | | | |
| Lifestyle related illness | | | | | | | | | | | | | | |
|  | | | When | | | | | Results | | | | | Treatment | |
| Tested for Hep B | | |  | | | | |  | | | | |  | |
| Tested for Hep C | | |  | | | | |  | | | | |  | |
| Tested for HIV | | |  | | | | |  | | | | |  | |
| COPD | | | | | | | | | | | | | | |
| Cognitive impairment | | | | | | | | | | | | | | |
| **Physical Health:** (Please request an up to date medical summary from the service user GP and include it with this referral form)  Liver Damage: Yes ⬜ No ⬜ Jaundice: Yes ⬜ No ⬜ Ascites: Yes⬜ No ⬜ Oedema: Yes ⬜ No ⬜ Pressure Sore: Yes ⬜ No ⬜ | | | | | | | | | | | | | | |
| If the client does not have a current GP please list any medications that you are aware of in this section: | | | | | | | | | | | | | | |
| Does the client feel they have any disabilities?Yes ⬜ No ⬜  If yes, please state any special requirements needed?  **History of Seizures:** Yes ⬜ No ⬜ (please describe any known patterns)  Alcohol related ⬜ Epilepsy ⬜ | | | | | | | | | | | | | | |
| **Mental Health: (Please provide any correspondence, summaries of past and present psychiatric care and include with this referral form)** | | | | | | | | | | | | | | |
| Current mental health: (i.e. depressed mood, suicidal ideation, psychosis)  List any hospital admissions - to include any recent diagnosed issues which would not be covered from GP and Psychiatric summaries: | | | | | | | | | | | | | | |
| **7. Risk assessment** | | | | | | | | | | | | | | |
| Risk | | | Yes or No | | | High or Low | | | | | Comments | | | |
| History of previous suicide attempts / overdose | | |  | | |  | | | | |  | | | |
| History of, or current suicidal ideation / Low affect | | |  | | |  | | | | |  | | | |
| Suffers from major mental health issue | | |  | | |  | | | | |  | | | |
| Significant past history of violence | | |  | | |  | | | | |  | | | |
| Current thoughts or plans indicating a risk of violence | | |  | | |  | | | | |  | | | |
| Past history of arson | | |  | | |  | | | | |  | | | |
| Has injecting related viral infection | | |  | | |  | | | | |  | | | |
| Involvement in high risk sexual behaviour | | |  | | |  | | | | |  | | | |
| Cognitive impairment | | |  | | |  | | | | |  | | | |
| Has serious physical health issues or unmet needs | | |  | | |  | | | | |  | | | |
| Current housing situation | | |  | | |  | | | | |  | | | |
| Contact with Social Services or Children’s Services | | |  | | |  | | | | |  | | | |
| Forensic history | | |  | | |  | | | | |  | | | |
| Contact with significant others | | |  | | |  | | | | |  | | | |
| Sexual offences, inappropriate sexual behaviour | | |  | | |  | | | | |  | | | |
| **8. History of aggression or violent behaviour** | | | | | | | | | | | | | | |
| Please give details: | | | | | | | | | | | | | | |
| **9. Social Support** | | | | | | | | | | | | | | |
| Please state agencies involvement, support network, family: | | | | | | | | | | | | | | |
| **Activities of Daily Living Skills** | | | | | | | | | | | | | | |
| Is the client able to manage finance? Yes ⬜ No ⬜  Is there an agreement in place to manage finance?  Please provide details  Does the client have interests in any social or recreational activities? Yes ⬜ No ⬜  Please provide details  Does the client able to manage personal care? Yes ⬜ No ⬜  Details of support required if needed | | | | | | | | | | | | | | |
| **10. Childcare** | | | | | | | | | | | | | | |
| Does the client have responsibility for children under the age of 18?Yes ⬜ No ⬜  (Please specify):  Are any childcare agencies involved? Yes ⬜ No ⬜  (If yes please identify with contact name and Tel No):  Does client have sole care? Yes ⬜ No ⬜  (If yes, please identify and specify childcare arrangements during admission)  (If no, who has care for child/ren): | | | | | | | | | | | | | | |
| **Safeguarding** | | | | | | | | | | | | | | |
| Does the client have any current safeguarding matters? Yes ⬜ No ⬜  (Please specify):  Are any agencies involved? Yes ⬜ No ⬜  (If yes please identify with contact name and Tel No): | | | | | | | | | | | | | | |
| **11. Legal** | | | | | | | | | | | | | | |
| Is client on probation and are there any current or outstanding warrants/charges, in prison etc.:  Probation Officer: Probation office:  Telephone No:  Email address: | | | | | | | | | | | | | | |
| **Who will be the lead person to liaise with regarding aftercare?**  Name:  Telephone No:  Email address:  Please describe what plan will be in place should your client be discharged or self-discharge before planned date: | | | | | | | | | | | | | | |
| **14. Consent - please ensure the client signs this section** | | | | | | | | | | | | | | |
| I give consent to ACH to share information about my treatment with:  Agencies involved in my treatment: Yes ⬜ No ⬜  For data collection and statistical purposes: Yes ⬜ No ⬜  GP:Yes ⬜ No⬜  Partner, friend or family: Yes ⬜ No⬜ (Please state)  Has the client been offered a copy of this treatment plan? Yes ⬜ No⬜  Client Name: Signature: Date: | | | | | | | | | | | | | | |
| **Completed by:** | | | | | | | | | **Signed:** | | | | | |

Note: To comply with care standards, the referral agencies should ensure that their service user have access to advocacy services thought out the referral process