**Aspinden Care Home – Referral Form**

|  |
| --- |
| Aspinden Care Home1 Aspinden RoadLondon SE16 2DR**Phone:** 020 7237 0331 **Email:** Enquiries.ACH@equinoxcare.org.uk **Web:** [www.equinoxcare.org.uk](file:///C%3A/Users/damian.callender/AppData/Local/Temp/246/Temp1_information%20%282%29.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:**

|  |
| --- |
| 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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 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 detailsDoes the client have interests in any social or recreational activities? Yes ⬜ No ⬜ Please provide detailsDoes 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