# **A black and red text Description automatically generatedWillowdene women’s residential programme referral Form**

# Instructions for Completion

Please complete this form in full and return it to Willowdene Rehabilitation Limited. Please ensure that all sections are completed. Where a section, or portion of a section, does not apply, please indicate “N/A” – in order to expedite the assessment and admission process, please **do not** leave any box blank. The service-user **must sign** the **‘Release of Information’** below, in order that we have consent to obtain information from GPs and other professionals, where strictly necessary for the evaluation and processing of their application for a placement.

# Confidentiality

All information received as part of a referral is treated as confidential and subject to our internal data protection policy and procedure.

# Submitting the Referral Form

Please submit completed forms to:

* By Post:

Mrs Sarah Home, Director of Care, Willowdene Rehabilitation Limited, Chorley, Bridgnorth, Shropshire, WV16 6PP

* By Email:

Sarah.Home@willowdenefarm.org.uk **or** care.manager@willowdene.cjsm.net

For queries or further information, please email info@willowdenefarm.org.uk or call (01746) 718658

# Privacy

Please visit the following page to view our privacy policy for handling referrals to our services. **https://willowdenefarm.org.uk/privacy-notice-for-referrals**

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| CONSENT FOR RELEASE OF INFORMATION | | |
| **Name** | **Signature** | **Date** |
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| CLIENT COMMITMENT | |
| The client needs to be motivated to participate in trauma-focused therapy, as well as all other aspects of the programme, so it is important that they are fully aware of the requirements of the programme and are prepared to fully commit to meeting those requirements. | |
| Has the programme been discussed with the client? | (YES/NO) delete as applicable | |
| Is the client fully committed to participating in the programme to the best of their ability? | (YES/NO) delete as applicable | |

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| COMPLETION CHECKLIST | |
| Please complete this checklist to ensure that all required sections and other relevant sections have been completed prior to submission. | |
| Section | Completed? (Yes No N/A) | |
| Client Commitment |  | |
| General Information |  | |
| Risk Information |  | |
| Criminal Justice |  | |
| Substance Misuse |  | |
| Physical Health |  | |
| Mental Health |  | |
| Medication |  | |
| Exit Plan |  | |
| Contingency Plan |  | |

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| GENERAL CLIENT INFORMATION | | | | | | | | | | | | | |
| **REQUIRED SECTION**. Please complete each question in this section. Where additional information is requested, please provide as much detail as possible. | | | | | | | | | | | | | |
| Client name |  | | | | | | | | | | | | |
| Date of birth |  | | | | | | | | | | | | |
| Marital status (please circle) | Married | | Single | Divorced | | | | Separated | | Partner | | Widowed | |
| NI number |  | | | | | | | | | | | | |
| Address |  | | | | | | | | Telephone Number(s) | |  | | |
| Telephone number(s) |  | | | | | | | | | | | | |
| E-mail |  | | | | | | | | | | | | |
| Next of kin | Name: | | | | | |  | | | | | | |
| Relationship: | | | | | |  | | | | | | |
| Address: | | | | | |  | | | | | | |
| Emergency contact number: | | | | | |  | | | | | | |
| Nationality |  | | | | | | | | | | | | |
| Ethnic Origin: |  | | | | | | | | | | | | |
| Religion |  | | | | | | | | | | | | |
| Employment status (please circle) | Employed | Self-employed | | | Unemployed | | Long-term sick | | | | Disabled | | Other |
| Parental status | Does the client have children? | | | | | (YES/NO) delete as applicable | | | | | | | |
| If the client has children, complete the following information for each child: | | | | | | | | | | | | |

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| Parental status (Continued) | Name of child | Date of birth | Parental responsibility? |
|  |  | (YES/NO) delete as applicable |
|  |  | (YES/NO) delete as applicable |
|  |  | (YES/NO) delete as applicable |
|  |  | (YES/NO) delete as applicable |
| Details of contact:  (please circle all that apply and provide any additional relevant information in the space provided) | Sole Custody | Joint Custody |
| Daily Visits | Weekly Visits |
| Supervised Visits | Access |
| Barred Access | Other |
| Please provide further details of contact arrangements in the space below: | |
| Is the client pregnant? | YES NO UNKNOWN (please circle) | |
| What care would be arranged whilst the client is in treatment? |  | |
| Does the client have any significant medical history (current or past)?  *Please provide details, if applicable* |  | | |

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| REFERRER AND KEY PROFESSIONALS’ INFORMATION | | |
| **REQUIRED SECTION**. Please complete each applicable question in this section. Where additional information is requested, please provide as much detail as possible. | | |
| Referral agency | Agency/organisation: |  |
| Key worker: |  |
| Main office address: |  |
| Telephone: |  |
| Email address: |  |
| GP | Practice/surgery: |  |
| Name: |  |
| Full address |  |
| Telephone number: |  |
| E-mail address |  |
| NHS number: |  |
| Mental Health/Other Medical Interventions | Practice/surgery/organisation: |  |
| Name: |  |
| Full address |  |
| Telephone number: |  |
| E-mail address |  |
| HMPPS Contacts (if applicable) | Offender Manager: |  |
| Full address |  |
| Telephone number: |  |
| E-mail address |  |
| Substance Misuse Worker (if applicable) | Agency/organisation: |  |
| Name: |  |
| Full address |  |
| Telephone number: |  |
| E-mail address |  |

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| RISK INFORMATION | | |
| **REQUIRED SECTION**. Please complete each question in this section. Where additional information is requested, please provide as much detail as possible. | | |
| Risk Information  *Please attach latest risk assessment.* | Risk of harm to other residents? | (YES/NO) delete as applicable |
| Risk of harm to staff? | (YES/NO) delete as applicable |
| Risk of self-harm? | (YES/NO) delete as applicable |
| Conviction for arson? | (YES/NO) delete as applicable |
| Any offences against children? | (YES/NO) delete as applicable |
| History of violence? | (YES/NO) delete as applicable |
| History of sexual offences? | (YES/NO) delete as applicable |
| If risk of harm assessment highlights risks which may impact on the programme, please comment on how they could be mitigated or managed |  |

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| CRIMINAL JUSTICE | | | |
| **OPTIONAL SECTION**. Please complete this section if your client is currently engaged with HMPPS, irrespective of whether or not the referral is being made through a Criminal Justice pathway. Where additional information is requested, please provide as much detail as possible. | | | |
| Current offence(s)  (Alternative to Custody programme referrals) | Offence relating to referral: |  | |
| Is the client currently in custody? | (YES/NO) *delete as applicable*  *If yes, where?* | |
| Court date: |  | |
| Sentencing court: |  | |
| Any other outstanding charges not being dealt with in this PSR: | (YES/NO) *delete as applicable*  *If yes, please give details:* | |
| Previous offence(s)  (Intervention programme referrals as part of community based orders or licences; Diversionary programmes) | Type of order *(please circle)* | Community Based | Custodial Sentence |
| Offence details : |  | |
| Sentence date and details: |  | |
| Licence start date  *(if applicable):* |  | |

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| SUBSTANCE MISUSE | | | | |
| **OPTIONAL SECTION**. Please complete this section if your client has a current or past history of substance misuse, irrespective of whether or not the referral is being made through a Public Health pathway. Where additional information is requested, please provide as much detail as possible. | | | | |
| Drug usage (if applicable) | Is the client drug dependant? | | (YES/NO) *delete as applicable* | |
| Primary drug of choice | Name: | |  | |
| Age first started using this drug | |  | |
| How frequently is/was the client using it? | |  | |
| Secondary drug of choice | Name: | |  | |
| Age first started using this drug | |  | |
| How frequently is/was the client using it? | |  | |
| Other drug(s) used:  *(please list include current usage, scripts and dosage of all* ***non-prescription*** *drugs used)* | **Drug** | **Current Usage** | **Scripts** | **Dosage** |
| Opiates |  |  |  |
| Cocaine |  |  |  |
| Cannabis |  |  |  |
| Amphetamines |  |  |  |
| Tranquilisers *(non-prescribed)* |  |  |  |
| Alcohol |  |  |  |
| Crack |  |  |  |
| Alcohol usage (if applicable) | Is the client alcohol dependant? | | (YES/NO) *delete as applicable* | |
| Quantity: | |  | |
| Regularity: | |  | |
| Age first started using alcohol | |  | |
| Current substance misuse support accessed | Does the client receive support from any substance misuse team? | (YES/NO) *delete as applicable. If yes, please provide contact details, including organisation name, key worker name, contact number, email address* | | |

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| PHYSICAL HEALTH | | | |
| **REQUIRED SECTION**. Please complete each applicable question in this section. Where additional information is requested, please provide as much detail as possible. | | | |
| Current/past physical health issues | Does the client have any current physical health issues? | | (YES/NO) *delete as applicable* |
| Does the client have any past physical health issues? | | (YES/NO) *delete as applicable* |
| Please circle any of the conditions listed below that the client has. Please also provide any relevant additional information in the space provided, | | |
| Hearing impairment | Visual impairment | |
| Asthma | Diabetes | |
| Epilepsy | Liver condition | |
| Mobility | Other (please state below) | |
| Additional Information: | | |
| Mobility/Accessibility Issues | Please provide information regarding any specific mobility or accessibility issues the client has that may require reasonable adjustments, including details of the adjustments required. | | |
| Learning disabilities/ additional learning needs | Please provide information regarding any learning disabilities or additional learning needs the client has. | | |

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| MENTAL HEALTH | | |
| **REQUIRED SECTION**. Please complete each applicable question in this section. Where additional information is requested, please provide as much detail as possible. | | |
| Psychiatric history | Has the client ever seen a psychiatrist/mental health worker? | (YES/NO) *delete as applicable* |
| Date of last appointment: |  |
| Does the client have any significant current or past psychiatric history? | (YES/NO) *delete as applicable*  *If yes, please provide further information* |
| Diagnosed conditions and/or disorders | Does the client have any diagnosed mental health condition or personality disorder? | (YES/NO) *delete as applicable*  *If yes, please provide further information. Please also provide any supporting documentation if available* |
| Self-harm | Has the client ever attempted to harm themselves (including suicide attempts)? | (YES/NO) *delete as applicable*  *If yes, please provide further information* |
| Access to interventions | Has the client received any mental health intervention? | (YES/NO) *delete as applicable*  *If yes, please provide further information. Please also provide any supporting documentation if available* |
| Date of last intervention: |  |
| Agency name: |  |
| Contact telephone number: |  |

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| MEDICAL INFORMATION | | |
| **REQUIRED SECTION**. Please complete each applicable question in this section. Where additional information is requested, please provide as much detail as possible. | | |
| Is the client currently prescribed medication?  *Please list prescribed medication and dosage* |  | |
| Does the client have any allergies? *Please list if applicable* |  | |
| Has the client ever had any seizures or fits (including significant withdrawals)? *Please provide details, if applicable* |  | |
| Outstanding medical or dental appointments | Please provide details of any known outstanding medical appointments the client has as at the date of referral | 1 |
| 2 |
| 3 |
| 4 |
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| DISCHARGE PLANNING | |
| **REQUIRED SECTION**. Please complete this section, providing as much detail as possible. | |
| Please provide details of arrangements in place upon completion of the residential programme *(e.g. accommodation, further programme provision with another organisation, etc.)* |  |

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| CONTINGENCY PLAN FOR DEPARTURE | | | | |
| **REQUIRED SECTION**. Please complete this section, ensuring that each question is answered fully and providing as much detail as possible. | | | | |
| Departure from Willowdene upon completion of programme | Is your client transferring to another provider post- completion? | | (YES/NO) *delete as applicable*  If ‘Yes’, please provide details | |
| Is your client returning home post-completion? *(mode of transport)* | |  | |
| If travelling by public transport, how will this be funded? | |  | |
| Will they be accompanied? | | (YES/NO) *delete as applicable*  *If yes, who will accompany them?* | |
| Information required to ensure safe discharge in case of **early departure**.  This section is particularly used where a departure is unplanned and the information can help to ensure that the, while unplanned, their exit from our service is as smooth and safe as possible  *Note, this typically applies where your client* ***wishes to leave****, or is* ***asked to leave****, before the expected completion date* | Professional contact’s details | Name: | |  |
| Job role: | |  |
| Daytime telephone number: | |  |
| Evening telephone number: | |  |
| Family/friend contact details | Name: | |  |
| Relationship to client: | |  |
| Telephone number: | |  |
| Is the address used prior to admission safe to return to? | *If yes, please provide address details* | | |
| *If no, please provide details of where your client should be directed to* | | |
| What method of transport should your client use, and how will this be funded? |  | | |
| Who will accompany the client home? | Name: | |  |
| Telephone number: | |  |
| If no-one, do you deem them safe to travel home alone? | | (YES/NO) *delete as applicable* |
| When and where will your client be able to access a prescribing service *(if applicable)* |  | | |

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| CONFIRMATION AND AGREEMENT | | |
| Client | Signature |  |
| Date |  |
| Referrer | Signature |  |
| Date |  |