Self or Agent Referral Form

Please download and print this form.
It is not possible to complete the form on a screen.

Personal information

Title:	Gender: ☐ Male ☐ Female ☐ Other
First name:	If other please specify:
Preferred name:	Age:
Surname:	Date of Birth:
Address:	Home tel:
	Mobile:
Postcode :	Email:
Tick the activity areas at LINDENGATE that you are interested in: ☐ Gardening ☐ Woodcraft ☐ Craft ☐ Cooking ☐ Nature Conservation	

What are your long term goals? please tick all that apply:

Help in improving personal coping skills		Therapeutic activities that will occupy me		To improve social interaction	
To improve self esteem		Be more active		To learn new skills	
Other (please provide details)					

Please describe how you spend your time now (What do you do to keep yourself well?)

Please indicate which days you would prefer to attend (tick all that apply)

AM	PM	
☐	☐	Monday
☐	☐	Tuesday
☐	☐	Wednesday
☐	☐	Thursday

Where did you hear about Lindengate?

Health information:
Are there any health professionals, care co-ordinators or social workers involved in your care?

☐ **Yes** ☐ **No**

If Yes, please provide their details in the below boxes:

Name:	Address:
Job title:	
Work tel:	Postcode:
Mobile no:	Email

Name:	Address:
Job title:	
Work tel:	Postcode:
Mobile no:	Email

Do you have a current Care Plan and Risk Assessment? ☐ Yes ☐ No

If you have a current occupational care plan and / or a current risk assessment this must be included with this referral.

Have you attached a risk assessment or care plan? ☐ Yes ☐ No

Do you have any of the following health conditions?

If you answer yes to any of the questions, you will not necessarily be excluded from attending but the information will help Lindengate to work with you more effectively

☐ Heart trouble and/or blood pressure problems

☐ Asthma, Bronchitis and /or shortness of breath

☐ Diabetes or any other metabolic disease

☐ Epilepsy and/or fainting attacks (If yes, please complete the Epilepsy Personal Care Record on the last page)

☐ Migraine, loss of balance or dizziness

☐ Head Injury

☐ Allergies (such as medication, food, stings)

☐ Fractures, Tendon, Ligament/Cartilage damage

☐ Physical or other disability

☐ Psychiatric or mental ill health

Please answer the following questions

☐ Have you been hospitalised within the last 2 years?

☐ Are you registered as disabled?

☐ Are you or is there any possibility that you might be pregnant?

☐ Do you exercise on a regular basis (at least 3 times per week?

☐ Do you smoke?

☐ Do you have a history of self-harm or suicidal behaviour?

☐ Do you have a history of violence or abusive behaviour towards others or things around you?

☐ Do you have any criminal convictions?

☐ Do you have a history of alcohol or drug misuse?

☐ Do you take prescribed medication?

If you ticked any of the boxes on the previous page, please provide details in the box below:

How would you describe your current mental health?
(Do you have a diagnosed mental health condition?)

GP Contact Details

Contact name:	Address:
Contact phone:	
Email:	Postcode:

If we need to contact your GP or any other medical professional are you happy to give consent for this.

☐ Yes ☐ No

Emergency Contacts
In the event of an incident at Lindengate, who should we contact? (eg family member, carer, friend)

First contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile:	Email:

Second contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile:	Email:

Health Consent
If you consent to Lindengate holding health information about you or the person you are a carer for, so you or they can come and be a Gardener with us, please tick the box below to indicate your consent.

☐ I consent ☐ I do not consent

Video / Photograph Consent
It is our policy that where we are planning to use an image (photograph or video) for materials in the public domain, consent must be obtained by the appropriate person. Consent can be changed or withdrawn at any time by notifying a member of staff. However, we cannot withdraw images already published.

Please tick which of the following may be used for publicity material:

Anonymous photographs or video where face cannot be seen or is obscured?	☐ Yes	☐ No
Identifiable photographs or video of face?	☐ Yes	☐ No
Video interview face-to-face?	☐ Yes	☐ No

Keeping in touch in accordance to Data Protection (GDPR)
All information provided on this referral form and in any further dealings with Lindengate will be treated as confidential and will not be disclosed to any third party outside of Lindengate without express consent from the client**.**
From time to time Lindengate may need to contact you (for example, if there was to be closure due to weather etc.) If you agree to us contacting, you for this purpose please tick to indicate that you consent:

☐ I consent ☐ I do not consent

Signature

Signed by Client: …… Date: ……

Or signed on behalf of client

Signed by Referrer: …… Date: ……

If referred by Agent please provide details

Name:	Address:
Job Title	
Organisation	Postcode:
Contact no:	Email:

Equal Opportunities

How would you describe your ethnic origin?
The following categories are recommended by the Commission for Racial Equality.

A **White**
☐ British
☐ Irish
Any other white background please write here: _____

B **Mixed**
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
Any other mixed background please write here: _____

C **Asian or Asian British**
☐ Indian
☐ Pakistani
☐ Bangladeshi
Any other Asian background please write here: _____

D **Black or Black British**
☐ Caribbean
☐ African
Any other Black background please write here: _____

E **Chinese or other ethnic group**
☐ Chinese
Any other ethnic background please write here: _____

Return address
Please return to: Lindengate, The Old Allotment site, Wendover Rd, Wendover, Aylesbury. HP22 6BD
or email: referrals@lindengate.org.uk
or fax: 01296 695402

Epilepsy Personal Care Record Date:

Please complete if required

Name	
Type and description of seizure	
Normal seizure length	
Frequency of seizures	
Date of last seizure	
Known triggers	
Normal recovery time	
Prescribed medication (name and time taken)	
Medical alert card/bracelet location	
Any history of status epilepticus	
Any emergency medication to be administered	