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Referral Form

This form needs to be completed with the client by the relevant care professional.

Please download this form before editing fields.
Data entered on the internet browser may not be saved.

Date received: ________________ **Staff Initials:** _________

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** ☐ **Woodwork** ☐ **Craft** ☐ **Cooking** ☐ **Nature Conservation**		

What are your long term aim(s)? 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	

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

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Where did you hear about Lindengate?

Do you have any of the following needs or difficulties: (If you answered 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 Seizure Recording Sheet 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.

☐ 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?

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If you have answered 'Yes' to any of the questions, please provide details in the box below:

How would you describe your current mental health needs? (Please tell us about your diagnosis)

Health information:

Do you have a health professional, care coordinator or social worker 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**

If we need to contact your health professional, care coordinator or social worker to obtain information we need to assess your level of support needs, are you happy to give consent for this. ☐ **Yes** ☐ **No**

Signed by Client: …………………………………………………………… Date: ……………………

Or signed on behalf of client

Signed by Referrer: …………………………………………………………. Date: …………………….

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GP Contact Details:

Contact name:	Address:
Contact no:	
Email:	Postcode:

Emergency Contacts:

In the event of an incident on site who should we contact (Family member, Carer, Friend)

First contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile no:	
Email:	

Second contact name:	Address:
Relationship to you:	
Home tel:	Postcode:
Mobile no:	
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. Image consent can be changed or withdrawn at any time by notifying a member of staff. However, we cannot withdraw images already published (please circle) for still or moving image(s) to be used for publicity material.

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

Keeping in touch in accordance to Data Protection (GDPR)

All information provided on the 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**.** If we are under a duty to disclose or share your data in order to comply with any legal obligation e.g. safeguarding children or vulnerable adults, acts of terrorism or money laundering we are obliged to cooperate.

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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**

Signed by Client: ………………………………………………………………… Date: ……………………

Or signed on behalf of client

Signed by Referrer: ……………………………………………………………. Date: …………………….

Referring care professional's details

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

How would you describe your ethnic origin? The following categories are recommended by the Commission of 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: ______________________________

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See overleaf for Epilepsy Personal Care form if required.

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

Epilepsy Personal Care Record Date:

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	
Any history of status epilepticus	
Any emergency medication to be administered	

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