**Fairhome Care Group (Fern Lodge) Limited**
**Fern Lodge**
**5 Eversley Park**
**Chester**
**Cheshire**
**CH2 2AJ**

**Tel: 01244 372288**

## NEW SERVICE USER REFERRAL FORM

**Applicants Full Name:** ……………………………………………………………………

**Title: Mr/Mrs/Miss etc:** ……………………………………………………………………

**Present Address:** ……………………………………………………………………

**Do they have their own tenancy?** ……………………………………………………………………

**How long at above address?** ……………………………………………………………………

**Date of Birth:** ……………………………………………………………………

**Religion:** ……………………………………………………………………

**Applicants' Consultant Psychiatrist:** ……………………………………………………………………

**Next of Kin and Address:** ……………………………………………………………………

**Social History (including any family/personal difficulties)**
**Give past and present detailing events and dates:**

**Medical/Psychiatric History and Present Medication**
**(Give past and present history, list previous hospital admissions – is there a specific diagnosis?)**

**Please give in-depth details of the points below that are relevant, with dates:**

1. Suicidal attempts – if yes, give precipitating factors

2. History of arson

3. Criminal offences (past and pending)

4. Violence or aggression (verbal/physical to self/family/others)

5. Antisocial behaviour

6. Alcohol/drug abuse

7. Episodes of absconding

8. History of cognitive impairment

9. History of self harm

**Please give a detailed report on the following areas commenting on the level of support required:**

1. Standard of personal hygiene

2. Physical condition/impairments

3. Domestic skills (cleaning, laundry etc.)

4. Budgeting skills

5. Communication /interaction skills

6. Compliance with medication – (self-medication)

7. Sleeping pattern

8. Special diets

9. Spiritual needs

10. Hobbies/interests

**Up to the date of this referral, how long has this person been considered suitable for community living or a more independent lifestyle?**

**Have there been any past (successful or otherwise) periods of living in the community?**
**(Give reasons if placements were unsuccessful)**

**Identified needs of applicant, (how needs were formulated and reasons for referral):**

**Is funding in place?**

If so who is responsible?

**Please include a summary of the Single Care Management (Health & Social Services) assessment (integrated with CPA) and a copy of the Single Care Plan:**

**Name of relative, significant other, advocate to be consulted (permissions must be sought from service user):**

**Name and title of person completing form:**

**Name of nominated keyworker to follow up referral at review meetings:**

**Date: ……………………………………… Signature: ………………………………………………..**