



Fairhome Care Group (Maryhill) Limited
568 Maryhill Road
Maryhill
Glasgow
G20 7EE

Tel: 0141 946 0886
Fax: 0141 945 2749

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:

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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 CC1 (that has been completed within the past 3 months) with this referral form:

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

Name and title of person completing form:

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

Date: Signature: