REFERRAL ASSESSMENT FORM

PERSONAL INFORMATION

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First Names:

Last Name:

Address:

Postcode:

Telephone:

Mobile:

D.O.B:

Mobile:

EMERGENCY DETAILS

Contact Name 1:

Contact Name 2:

Relationship to you:

Relationship to you:

Phone Number:

Phone Number:

DISABILITY

Learning Disability ☐ Hearing Impairment ☐ Profound and Multiple Disability ☐

Long Term Health Condition ☐ Mental Health Issues ☐ Learning Difficulty ☐

Physical Disability ☐ Visual Impairment ☐ Other *..

If you have ticked any of the above disabilities, please specify:

HEALTH

Tell us about the general state of your health?:

How might your health/disability affect the way you live your life?:

Are there any changes that may need to be made for whilst receiving a service from us or at work?

Are there any changes that may need to be made for whilst receiving a service from us or at work?

Are you on any medication? Yes * No *

If so please give details of medication and how often it needs to be taken:

Is there any special equipment or aids that you need whilst receiving a service from us or at work?

REFERRAL DETAILS

Disability Employment Advisor ☐ Local Authority Worker ☐ Self Referred ☐

Health Authority Worker ☐ Job Centre Advisor ☐ Parent/Carer ☐

Other Personal Advisor ☐ Other Support Worker ☐ College Worker ☐

Name: ....

CURRENT ACTIVITIES

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

OTHER INFORMATION

Hobbies and Interests?

Are you able to travel independently? Y/N

Any other comments:

DATA PROTECTION

The information contained in this form will be used by Nickel Support for the purposes of finding the right day service, training or employment opportunity and will form part of a trainee file. Nickel may disclose some of the information contained in this form, and subsequent file, to other training providers or employers for the purposes of arranging the most suitable day service, training or employment opportunity.

Signed:

Name:

Date: