

Referral Form



Personal information:

Title:		Gender:	
First name:		Ethnicity:	
Surname:		DoB:	
Address:		Home tel:	
		Mobile	
Postcode :		Email:	
Activity area at TWIGS that you are interested in : (when available) (when available)			
Gardening	Woodcraft	Art	Craft

Your Aim(s): *please tick all that apply*

Therapeutic activities that will occupy me	<input type="checkbox"/>	Further education & learning	<input type="checkbox"/>	Supported employment	<input type="checkbox"/>
Help in improving personal coping skills in the workplace	<input type="checkbox"/>	Training	<input type="checkbox"/>	Gaining employment	<input type="checkbox"/>
Voluntary work in the community	<input type="checkbox"/>	Work experience	<input type="checkbox"/>	Retaining a job	<input type="checkbox"/>
Career / Job advice and guidance	<input type="checkbox"/>	Employment support	<input type="checkbox"/>	Sustaining employment	<input type="checkbox"/>

Your current occupational activities:

Please describe how you spend your time now: ie any volunteering, education etc

If you are unemployed, how long have you been unemployed? *Please tick one*

Less than 6 months 6 – 12 months 1 – 3 years
 Over 5 years Never worked

Qualifications

Have you achieved any qualifications? Yes No

If yes, what is the highest level of qualification you have achieved?

Health Information:

Approximately when did you first experience mental health problems?

Is there any health professional or social worker involved in your care?

Yes No

Do you have a current Care Plan (Please circle) YES NO

Current Occupational Plan, Care Plan and Risk Assessment

If a current Occupational Plan, Care Plan and/or a current risk assessment is available please include with this referral to avoid any delays.

Please provide a brief summary of your mental health problems:

Do you have any other needs or difficulties? *Please tick all that apply*

Learning difficulty	Physical disability	Aspergers Syndrome or autistic spectrum disorder
Drug or alcohol problem	Sensory disability	Other – please describe:

Referrer information:

Referrer Name:	Address:
Referrer Job Title:	
Work Tel	Postcode:
Mobile No	GP Name:
Email	Surgery Tel No:

Any other relevant information you wish to tell us

a) the referrer:

b) the client:

In accordance with the Data Protection Act of 1998, all information provided on the referral form and in any further dealings with TWIGS will be treated as confidential and will not be disclosed to any third party outside of TWIGS without express consent from the client.

Signed Client: Date:

Signed Referrer:Date:

Office use only: Date referral received: Date of initial meeting

(we will endeavour to respond within 5 working days)

Reasons not started: Service refused; Client refused; Health reasons; Other (please state)

Please return to TWIGS, c/o Manor Garden Centre, Cheney Manor, Swindon SN2 2QJ.
or email to twigs.reception@gmail.com