This information is being collected to assess your needs and how best we can help you, and to ensure that we have access to the information we need to protect your health and safety whilst you are using the services offered by Ty a Gofal.

To provide you with the services you need, it may be necessary to share relevant information about you with and work together with other services for your benefit. This may include Hywel Dda University Health Board, Carmarthenshire County Council and other charities/organisations. In some circumstances, like safeguarding people or preventing crime, we may also have a legal obligation to pass information about you on to another organisation.

Ty a Gofal takes our data protection responsibilities seriously and, in line with relevant data protection legislation, the information you give us on this form will be kept securely in a personal file / locked cabinet with access restricted to staff only. You have a right to see the information we hold in your file.

**TY A GOFAL REFERRAL FORM**

**Staff Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 1: Personal Details**

|  |  |
| --- | --- |
| Name of person referring |  |
| Organisation |  |
| Contact Number |  |
| Date |  |
| Any additional contacts: (Case/Support Worker) |  |

|  |  |
| --- | --- |
| Clients Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Contact Number |  |
| Email address: (Optional) |  |
| National Insurance Number |  |

|  |  |  |
| --- | --- | --- |
| Is the client aware of the referral? | YES | NO |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the client have a history of aggression? | YES | NO | UNKNOWN |
| Does client have a drug or Alcohol dependency? | YES | NO | UNKNOWN |
| Does the client pose a risk to others? | YES | NO | UNKNOWN |
| Any other relevant risk information (in possession of any substances or medication etc- please attach risk assessment) |  | | |

|  |  |
| --- | --- |
| Does the client have any dependents or lives with others?  Yes - Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Is there someone in their home that requires care? | animal  caring duties  children  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Are they known to Mental Health Services? | Yes  No |
| Are they on prescribed medication? | Yes  No |
| Do they use and Drug and/or Alcohol Services? | Yes  No |
| Any additional information (services known to etc) |  |

**Do they require assistance/reasonable adjustments for any of the following: -** (MARK AS APPROPRIATE)

Deafness or partial hearing loss (D) Blind or partial sight loss (B)

Physical disability (Phys-Dis)

Learning disability (for example, Down’s syndrome) (L-Dis)

Learning difficulty (for example, dyslexia) (L-Diff)

Developmental disorder (for example, Autistic Spectrum Disorder or Asperger’s Syndrome) (DD)

Long-term illness, disease or condition (LTC)

Notes:

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

**Are they currently experiencing any of the following problems or symptoms?**

(MARK AS APPROPRIATE)

Bereavement Bullying Debt / Financial Worries Domestic Violence

Drug / Alcohol dependency Eating Disorder Homelessness Memory Loss

Panic Attacks Relationship problems Sexual Abuse Sleep problems Stress

Other

|  |  |
| --- | --- |
| 1. **Emergency Contact Details** Relation: | |
| Name |  |
| Address: |  |
|  |
|  |
| Post code |  |
| Contact No. |  |

|  |  |
| --- | --- |
| 1. **GP Details** | |
| Name |  |
| Surgery Name/ Address: |  |
| Post code |  |
| Contact No. |  |

|  |  |
| --- | --- |
| Are you happy to be contacted to see how you are and to give feedback on this service : | text email phone post |

**Visitors Signature X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Ty a Gofal Staff use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Date received |  | | |
| Staff member |  | | |
| Referral accepted | YES | NO |  |
| If no Why |  | | |
| If Yes Client number |  | | |
| Client contacted | YES | NO |  |
| Date of contact |  | | |
| Initial contact comp. | YES | NO |  |