

Workbridge
Bedford Road
Northampton
NN4 7AD

Tel: 01604 823460
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CONFIDENTIAL CLIENT REFERRAL FORM

CLIENT DETAILS

Title:

First name(s):

Surname:

D.O.B

Likes to be called:

WARD CONTACT

Ward: _____ Tel No: _____ CPA Care Coordinator _____ Tel: _____

Division: _____ Designation: _____

OT: Name _____ Tel No: _____ Named Nurse: _____ Tel No: _____

RMO: _____

REFERRAL INFORMATION

Reasons for referral:

What goals have been defined and what do they expect to achieve in attending the *Pathway* programme:

1

2

3

Work Experience (Give details of any relevant previous experience gained)

What are the client's main strengths:

PROGRAMME DETAILS

In-reach:

W.W.A.S.P:

Indicate preferred Workshop(s) in order of priority: (1,2,3...)

Ceramics: Catering: General Contracting:

Work within the Community:

Office Skills: Horticulture: Woodwork & Maintenance:

Indicate preferred days/sessions: M T W T F

AM:

PM:

Indicate length of session suitable:

Whole session: 1 – 2 hours:

30 min – 60 min: 2 - 3 hours:

Requires Escort: Yes No

Escort to remain with Client: Yes No

OTHER INFORMATION

Please identify other agencies / activities currently accessed:

Risk Assessment attached Yes No & to Follow:

Existing Care Plan attached Yes No & to Follow:

Escort Plan attached: Yes No & to Follow:

Other programmes attached: (please specify)

Problems and Risks (details)	Relevant detail	Intervention agreed to manage/treat problems/risks (where relevant to referral)
Cognitive		
Behavioural		
Physical		
Special needs and other information: (Physical problems, epilepsy, special diet, allergies, inhaler, etc)		

Diagnosis

Medication (required at sessions):

Self Medication: Yes No

Possible effect of medication:

REFERRER

Referred By: _____ Date: _____ Position: ___ O.T. / T.I.

Contact telephone number:

WORKBRIDGE ADMINISTRATION ONLY.

Workbridge accepts Yes No Reason:

Agreed Start Date:

Review Period:

Session:

Client accepts Yes No Reason:

Service Manager

Date

Please attach Risk Assessment