



## REFERRAL FORM

### Information about client

<b>Name:</b>		
<b>Known As:</b>		<b>Date of Referral:</b>
<b>DOB:</b>	<b>Age:</b>	<b>Title:</b>
<b>Address:</b>		<b>Telephone Number:</b>
<b>Post Code:</b>		<b>Mobile Number:</b>
<b>Email address:</b>		

### Details of person making referral

<b>Name:</b>	<b>Telephone Number:</b>
<b>Address:</b>	<b>Mobile Number:</b>
<b>Post Code:</b>	<b>Email address:</b>
<b>Relationship to person being referred:</b>	

### GP Details

### Next of Kin Details

<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>Post Code:</b>	<b>Post Code:</b>
<b>Telephone Number:</b>	<b>Telephone Number:</b>

**Further Details**

Nature of disability:	Date of Injury:
Present Difficulties:	Other Services Involved:
Reason for Referral:	Is Client Aware of Referral:

**Additional Information Relevant to the Referral:**

**Known risks:**

a)

b)

c)

d)

**Behaviours which may challenge service providers or others and how these are best dealt with:**

a)
b)
c)
d)

In order to maintain positive reputations and the safety of people being referred, and to Care Workers of North East Community Care Ltd. It is important that all known risks and behaviours which are known, or, likely to challenge services, are recorded and made known to North East Community Care Ltd. prior to the commencement of a service being provided.

The person being referred and/or their legal guardian are required to give permission for health and social work professionals to give copies of Single Shared Assessments and reports of previous occurrences and behaviours which have challenged services.

*Please complete and sign the attached form giving professionals permission to forward assessments/reports/recommendations to North East Community Care Ltd.*

<b>Signed:</b>	<b>Date:</b>
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**Please Return to:**

North East Community Care  
Turriff Business Centre,  
Markethill Rd.  
Turriff.  
AB53 4AG

**Internal use only**

Date Received:	Date Referral Accepted:
Initial Contact Date:	
Referral Rejected for the Following Reasons:	



**Consent form**

*(Giving professionals permission to pass on information to NECC including Single Shared Assessments, Risk Assessments and any other relevant information to help NECC provide a suitable and appropriate service.)*

I (name of person requiring support.....)  
would like to give consent to professional people from Health Care  
and/or Social Work Departments who have current or previous  
involvement with my care and support to pass on information such  
as Single Shared Assessments, Risk Assessments and any other  
relevant information to help NECC provide a suitable and  
appropriate service).

Name and address of person requiring support:

Name:.....  
Address:.....  
.....  
.....

Signature of person requiring care/support or their legal guarding:

..... Date:.....