

Member Referral Form 2022

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| *Member details* |
| Forename: Surname:    Address: Tel. No: (Mobile)  Tel. No: (Home)      Postcode: Email:  Date of Birth: |
| *Referrer details* |
| Name of Referrer: Job Title:  Name of organisation/dept (if applicable):  Contact Address: Tel. No. (Work):  Tel. No. (Mobile):  Postcode: Email:  Service Area: *tick one only*  Learning Disability Physical & Sensory Disability Mental Health  Care Manager and Team (if different from above):  Tel. No. (Work): |
| *Main contact in case of an emergency* |
| Name: Tel. No. (Home)  Address: Tel. No. (Work)  Tel. No. (Mobile)  Postcode: Relationship to Member: |

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| *2nd Emergency contact details* | |
| Name: Tel. No. (Home)  Address: Tel. No. (Work)  Tel. No. (Mobile)    Postcode: Relationship to Member: | |
| *Disability diagnosis* | |
| **Diagnosis or statement of needs** e.g.: ASD, learning delay, Cerebral palsy, head trauma, epilepsy etc.   * Are there any physical disabilities or motor function impairments? * **Behaviour**s**;** Are there any behavioural issues such as walking off, challenging behaviour,   self-harm or vocalisations we should be aware of?   * **Triggers;** Are there any specific triggers that lead to challenging behaviours? * **Are there any communication issues?** Yes / No   *(Please specify and provide details of what support or help is required in order to communicate e.g. translator, hearing loss, communication delay. Please also provide details on preferred communication methods.)*   * **Diet:**   *Are there any specific dietary requirements we need to know about?*   * **Allergies**: * **Are there any other health concerns we should be aware of**?   (*Please give details if relevant*) | |
| *Medication* | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Medication | Type | Strength | Dose | Special instructions | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | |
| *Member’s Doctors details* | |
| Doctor’s Name: Surgery Tel. No.:  Surgery Address:  Postcode: | |
| *Other Relevant Information* | |
| What are you hoping to gain from your time at Missenden Walled Garden?  Do you have any long-term goals that we might help you towards?  Do you have any interests or experiences you would like to share with us, particularly those associated with horticulture. | |
| Payment | |
| The cost of a day session at ***MWG*** Is £52 | |
| Invoice Address | Payment Arrangement  (*e.g. Buckinghamshire CC, direct payment etc)* |
| Contact Name | Tel. No. (Mobile) |
| Email: | |

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| *Ethnic Origin* |
| *Please tick appropriate box. This information is used to help us with our provision.*  White British Mixed white & black Caribbean  Irish White & black African  Other white background White & Asian  Any other mixed background  Asian or Asian British: Black or Black British:  Indian Caribbean  Pakistani African  Bangladeshi Any other Black background  Any other Asian background  Chinese Any other ethnic group  Do not wish to give information |

Please be aware that Missenden Walled Garden needs to be informed immediately of any change in circumstances e.g., medication, address, contact details, emergency contact details, GP.

*Signature of Member*.……………………………………………………. Date ………………………………………….

*Signature of Care Manager / Parent / Carer*………………………………………………………………………..

Date …………………………………………

*Signature on behalf of*

*Missenden Walled Garden* ………………………………………………. Date ………………………………………..