

 Member Referral Form 2022

|  |
| --- |
| *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 HealthCare 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: |

|  |
| --- |
| *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: |

|  |
| --- |
| *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 ………………………………………..