



Prism

Participant Referral Form



Preferred language for future correspondence;

English

Welsh

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| Client's Name: | D.O.B: |
| Address; | |
| Telephone No. | |
| Referrer's Name: | |
| Referral Agency: | |
| Telephone No./ E-mail: | |
| National Insurance no: | |
| G.P Name: | Surgery details: |
| Contact No. | |
| Medical History: | |
| Current Medication: | |
| Any Side Effects That Would /Could Limit Work Placement: | |
| <p>*What benefits are the participants receiving? (Please tick all that apply)</p> <p>Jobs Seekers Allowance: <input type="checkbox"/> Start Date _____</p> <p>Incapacity Benefit: <input type="checkbox"/></p> <p>Employment Support Allowance: Work <input type="checkbox"/> Support <input type="checkbox"/> Start Date _____</p> <p>Disability Living Allowance: <input type="checkbox"/> Level _____</p> <p>Income Support <input type="checkbox"/></p> <p>Other <input type="checkbox"/> Please specify: _____</p> | |

Brief details of Substance Misuse history:

Does the participant have any additional support needs which we should know about?
Please describe:

When would you like to arrange a meeting and do you have any preferences about location?

Please give details of participant's interests and preferences for future development (i.e. Basic skills, soft skills, I.T teaching, job search/other),

Please attach any relevant information including a Risk Assessment which will help us assess the needs of the Participant.

To your knowledge has there been: (since last risk assessment)

Any suicidal ideation or action, or episodes of self harm?

If Yes, detail:

Any threats of or acts of violence to others (abusive behaviour)?

If Yes, detail:

Any gender or ethnic issues?

If Yes, detail:

Change in child care status?

If Yes, detail:

Any deterioration in self-care?

If Yes, detail:

Next of kin details:

Name:

Address:

Telephone No:

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|--|
| Referrer's Name: |
| Referrer's signature: |
| Participants signature: I can confirm that I give permission for this information to be shared with the Coastal Team: |
| Date: |
| Thank you for completing this form and for your referral. We will contact you on receipt of this form to arrange for an appointment. |
| Please note that these questions are designed to ensure that we have the information we need to ensure your client has a positive experience. However, if our project is not suitable for your referral, we will aim to help find alternative provision which better meets their needs. Please return to: Coastal, Prism, 5A Cowell Street, Llanelli, Carmarthen, SA15 1UU |
| For office use only. COASTAL ID No. Support Worker: First Meeting : |

Telephone - 01554 740040
Fax – 01554 758786

Please return to: Coastal, Prism, 5A Cowell Street, Llanelli, Carmarthen, SA15 1UU